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ABSTRACT

This report presents an overview of the drug phenomenon in Europe at the start of the new millennium. The first chapter begins with a discussion of overall drug trends. Specifically, it examines trends in drug use and the consequences including multiple drug use; problem drug use and demand for treatment; drug-related deaths; drug-related infectious diseases; and other morbidity. A discussion of the trends in response to drug use looks at policy and strategy development; prevention; reducing the harmful consequences of drug use; and treatment. Chapter two discusses the prevalence and patterns of drug use. Health consequences of drug use, law-enforcement indicators, and drug-market indicators (seizures, price, and purity) are covered in this chapter. The third chapter explains policy and strategy developments as well as demand-reduction responses as they relate to the drug use problem. Chapter four examines substitution treatment, prosecution of drug-related offenses, and problems facing women drug users and their children. The final chapter discusses the drug problem in Central and Eastern Europe. The prevalence and patterns of use and the responses to the problem are addressed in this chapter. (MKA)

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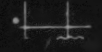

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Rua da Cruz de Santa Apolónia, 23-25
P-1149-045 Lisboa
Tel. (351) 21 811 30 00
Fax (351) 21 813 17 11
E-mail: info@emcdda.org
Website: http://www.emcdda.org

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# Preface

With this 2000 *Annual report on the state of the drugs problem in the European Union*, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) presents to the EU and its Member States an overview of the drug phenomenon in Europe at the start of the new millennium. Accurate information is essential for effective action, and by fulfilling the information needs of decision-makers at all levels, the EMCDDA is contributing significantly to the development of drug policy in Europe.

The annual report — prepared in close collaboration with the national and European Commission focal points of the Reitox network and other key partners — is the Centre's main information vehicle, and the data and analysis it contains are key for planning and implementing adequate measures to counter the drug problem at both national and EU level.

As data-collection and data-comparison methods remain variable throughout Europe, the EMCDDA is developing specific instruments to facilitate the analysis of drug-related legislation, policies and strategies in all Member States. To this end, five harmonised epidemiological indicators of drug use — surveys of the general population, estimates of the prevalence of drug use, demand for treatment, drug related deaths and drug-related infectious diseases — are being implemented. These indicators not only provide vital information on key aspects of the drug phenomenon, but also have a broader strategic value. The importance of evaluating the impact of policy on the drug problem is increasingly recognised, and it is on the basis of these five indicators that future such assessments will be made.

At its Helsinki meeting in December 1999, the European Council formally adopted the European Union Drugs Strategy (2000–04). This document sets six objectives to be achieved by the end of that period:

- to reduce significantly the prevalence of drug use and of new users under the age of 18;
- to reduce significantly the incidence of negative health consequences associated with drug use and drug-related deaths;
- to increase substantially the number of successfully treated addicts;
- to reduce substantially the availability of illicit drugs;
- to reduce substantially drug-related crime; and
- to reduce substantially money laundering and the illicit traffic in precursor chemicals.

The EMCDDA, in close collaboration with the European Commission and the EU Member States, is now putting in place the necessary instruments and methodologies to implement, monitor and evaluate the strategy over the next five years.

In line with the EU's drug-information policy, the United Nations International Drug Control Programme (UNDCP) is making a concerted effort — through its January 2000 'Lisbon consensus document' which endorses seven harmonised key indicators — to promote at international level an approach to data collection to complement that pursued at EU level by the EMCDDA.

The importance of the leading-edge role the EMCDDA plays at EU level in obtaining reliable and comparable drug information was reflected at international level by the Declaration of policy and fundamental principles of the reduction of demand for drugs, adopted in the framework of the United Nations General Assembly on Drugs in June 1998. This recognition, and the growing emphasis placed on evaluating demand-reduction activities as the basis for any successful national or international drug strategy, can only be seen as major steps forward in this field. I hope that you will find this report a step in that direction too.

**Georges Estievenart**
Executive Director

# Acknowledgements

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- the services within each Member State that collected the raw data for this report;
- the Members of the Management Board and the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);
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- the Pompidou Group of the Council of Europe, the United Nations International Drug Control Programme, the World Health Organisation, Europol, Interpol, the World Customs Organisation and the Centre for the Epidemiological Monitoring of AIDS;
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- Mike Ashton and Rachel Neaman;
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Chapter 1

# Overall trends

## Trends in drug use and its consequences

### Cannabis

Cannabis remains the most widely available and commonly used drug across the EU, with substantial increases in use over the 1990s. Continuing rises in countries with previously lower levels and some stabilisation in higher-prevalence countries confirm the tendency towards convergence noted last year.

• At least 45 million Europeans (18 % of those aged 15 to 64) have tried cannabis at least once. Around 15 million (about 6 % of those aged 15 to 64) have used cannabis in the past 12 months.

• Use is higher among younger age groups. About 25 % of those aged 15 to 16 and 40 % of those aged 18 have tried cannabis. In some countries, use has doubled since 1990, in others the rise is less marked and in a few it has stabilised.

• 'Curiosity' is a primary motive for trying cannabis, and use is more experimental or intermittent than persistent.

• The increase in numbers attending treatment centres for cannabis use noted last year is confirmed, especially among younger clients. Additional drugs are also often involved.

• Cannabis remains the primary drug in drug offences, mostly for use or possession rather than trafficking. Numbers of seizures have increased sharply since 1997.

### Amphetamines and ecstasy

Amphetamines and ecstasy are the second most commonly used drugs in Europe. Following increases in the 1990s, ecstasy use appears to be stabilising or even falling, while amphetamine use is stable or rising.

• Between 1 and 5 % of those aged 16 to 34 have taken amphetamines and/or ecstasy. Rates are higher in narrower age groups, but rarely exceed 10 %.

• The proportion of clients seeking treatment for amphetamine or other stimulant use is low, but increasing in some countries.

• Drug use continues to shift away from large dance events to more geographically diffuse club, bar and private settings.

• A wider range of drugs and patterns of use are observed, linked to different social groups and lifestyles.

• Both the numbers and quantities of amphetamine seizures stabilised in 1998. Ecstasy seizures have been stable since 1997, although the quantities involved fluctuate.

### Cocaine

While cocaine is less commonly used than amphetamines or ecstasy, its use is rising — particularly among socially active groups — and spreading to a broader population.

• Between 1 and 6 % of those aged 16 to 34 and 1 to 2 % of schoolchildren have tried cocaine at least once, although some surveys show levels of up to 4 % among 15 to 16-year-olds.

• Higher levels of use are found among socially outgoing, employed young adults in urban centres.

• Cocaine tends to be used experimentally or intermittently and is usually sniffed in powder form.

• Many clients treated for heroin use also use cocaine either intravenously or smoked as 'crack'.





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• Severe problems associated with smoking 'crack' have been identified, particularly among female sex workers.

• The proportion of clients seeking treatment for cocaine use is increasing in many countries. How far this is linked to heroin use or has developed from heavy recreational use of other drugs is unclear.

• In 1998, numbers of cocaine seizures continued to increase, while the quantities involved fluctuated.

### Heroin

Heroin dependence remains broadly stable. Known users are a largely ageing population with serious health, social and psychiatric problems, although indications of heroin use amongst some younger groups are noted.

• Heroin experience overall remains low (1 to 2 % in young adults) and school surveys show pupils are highly cautious about using heroin.

• Some countries report anecdotal evidence of increased heroin smoking among young people, and some school surveys reveal greater experimentation.

• Heroin use is reported amongst young, heavy, 'recreational' users of amphetamines, ecstasy and other drugs. Other high-risk groups include marginalised minorities, homeless young people, institutionalised youth and young offenders, prisoners (women in particular) and sex workers.

• New clients entering treatment for heroin use are less likely to inject and more likely to smoke the drug than clients returning to treatment.

• Numbers of heroin seizures and the quantities involved are stable across the EU, although variations exist between countries.

### Multiple drug use

Patterns of weekend and 'recreational' drug use increasingly involve combinations of illicit and licit drugs, including alcohol and tranquillisers.

• 'Nightlife' studies reveal heavy multiple drug use by a minority of young people.

• Use of synthetic drugs such as ketamine and gamma-hydroxybutyrate (GHB) is reported, but is much less common than use of amphetamines or ecstasy.

• More significant is the increase in cocaine use, often in conjunction with heavy alcohol consumption.

• Abuse of volatile substances (lighter fuel, aerosols, glue) is often more common amongst schoolchildren than amphetamines and ecstasy, and is increasing in some countries.

### Problem drug use and demand for treatment

Patterns of problem drug use — often characterised as 'addiction', especially to heroin — are changing across the EU. In addition to heroin dependence, problem use of cocaine (often with alcohol), multiple use of drugs such as amphetamines, ecstasy and medicines, and heavy cannabis use are emerging.

• The EU has an estimated 1.5 million problem drug — mainly heroin — users (between two and seven per 1 000 inhabitants aged 15 to 64). An estimated 1 million are likely to meet clinical criteria for dependence.

• The proportion of clients entering treatment for heroin use is generally declining, while new admissions for cocaine or cannabis use show some increases — especially among young clients.

### Drug-related deaths

The number of acute drug-related deaths (overdoses or poisonings) has stabilised across the EU following marked increases in the second half of the 1980s and early 1990s. Trends vary, however, among countries.

• Stable or decreasing rates may be linked to stable or decreasing prevalence of heroin, safer usage or increased access to treatment, especially substitution programmes.

• Countries with previously low numbers of acute deaths directly linked to drug administration ('overdoses') report substantial rises in recent years. This may reflect increased prevalence of problem drug use, but also improved recording practices.

• Other countries continue to report less sharp, but steady increases in acute deaths.

• Numbers of drug-related deaths are significantly higher among men than women, reflecting the higher prevalence of problem drug use in males.

• Most acute deaths involve opiates, often in combination with alcohol or tranquillisers. Some countries report significant numbers of deaths from volatile substances among adolescents. Deaths from cocaine, amphetamines or ecstasy are uncommon.

• Overall annual mortality among problem drug users has fallen in some countries, following rises over several



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years. This reflects a drop in overdose and AIDS deaths and indicates that some deaths are preventable.

### Drug-related infectious diseases

Overall trends in HIV and hepatitis B and C prevalence among injecting drug users appear relatively stable, although some local increases in HIV infection are reported.

• Incidence of new AIDS cases varies greatly between countries, but generally continues to fall, probably because of new treatments that delay onset.

• Prevalence of hepatitis C infection among drug injectors is high — between 50 and 90 % — even in countries with low rates of HIV infection.

• Trends concerning hepatitis B are difficult to identify because the presence of antibodies may indicate vaccination rather than infection.

• Risk behaviours that may transmit infection are of concern. High-risk groups include: young injectors not exposed to earlier education campaigns; women, who tend to share injecting equipment more than men; heroin injectors who also use cocaine; and imprisoned drug users.

### Other morbidity

Possible long-term neural damage linked to heavy use of ecstasy is a growing concern.

• Increasing numbers of studies with both animals and humans suggest that chronic exposure to ecstasy causes functional and morphological changes in the parts of the brain that regulate physiological and psychological functions such as sleep, appetite, mood, aggression and cognition.

• Some studies report mild cognitive impairment in heavy ecstasy users, but the scientific literature is inconsistent regarding other functions. Other unresolved issues include the 'dangerous' dose range, frequency of use and whether deficits are reversible.

• Use of GHB — which in small doses diminishes tension but in marginally larger doses can cause potentially fatal intoxications, particularly when taken with alcohol and other sedatives — is also causing concern.

## Trends in responses to drug use

### Policy and strategy developments

New drug strategies have been adopted by Spain, France, Portugal and the UK as well as by the European Union itself.

• National drug policies are becoming more balanced in approach, with greater emphasis placed on demand reduction relative to supply reduction.

• The drug problem is increasingly viewed in a broader social context and common aims include drug prevention, reduction of drug-related harm and crime deterrence.

• Accurate scientific evidence, clear objectives, measurable performance targets and evaluation are key to these strategies.

• Depenalisation of drug use offences is becoming more common. The consensus is emerging that drug users should not be imprisoned because of their addiction, and alternatives provided in law are increasingly implemented.

### Prevention

Drug prevention in schools, recreational settings and among high-risk groups is a priority in all EU Member States.

• School drug-prevention programmes combine information for pupils with training in life skills such as self-assertiveness. Peer-group approaches actively involve young people in implementing prevention activities in their schools.

• Specific training and guidelines for teachers, as well as initiatives targeting parents, are increasingly being developed.

• Use of the Internet as an educational tool for pupils, teachers and parents alike is growing.

• Drug-prevention training for youth workers, night-club and bar staff is being introduced in some countries.

• Prevention of synthetic drug use is becoming more professional, combining information, outreach work, counselling and sometimes pill testing.

• Local cross-sector youth policies are being developed to meet the needs of high-risk groups.

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• Evaluation methodology to assess outreach work with high-risk groups is urgently needed and the EMCDDA is developing guidelines to bridge this gap.

## Reducing the harmful consequences of drug use

Reducing the harmful consequences of drug use is key to the drug strategies of many Member States.

• Syringe-exchange programmes are expanding across the EU and activities are intensifying to counter falling awareness of the risks of injecting.

• Outreach work and low-threshold services are growing as a complement to conventional drug-treatment centres.

• 'Users' rooms', where drugs can be consumed under hygienic and supervised conditions, remain controversial and a study funded by the European Commission is evaluating their effectiveness.

## Treatment

To cope with the growing numbers and divergent needs of those seeking treatment for drug use, diversified patterns of care are being developed throughout the EU.

• Cooperation has increased between youth and social services and conventional drug services, which alone are often inadequate to treat new drug-use patterns and new target groups.

• Specialised services for women exist across the EU, many specifically targeting pregnant women and mothers with children, as well as female sex workers.

• Public-health and psychiatric services are increasingly involved in the treatment of multiple-drug use.

• Substitution treatment is expanding — including in prisons — both in terms of the numbers of clients and the substances used.

• Awareness of the need for adequate after-care for drug users leaving treatment or prison — or for those in long-term substitution treatment — has risen considerably.

• A large proportion of the prison population are drug users and treatment is increasingly provided to avoid relapse into illegal drug use and crime.

Chapter 2

# Prevalence and patterns of drug use

This chapter gives an overview of the prevalence, patterns and consequences of drug use across the EU based on surveys, routine statistics and other research. Emphasis is placed on national data, which may mask local or emerging phenomena.

## Prevalence of drug use

### Drug use in the general population

National surveys of drug use in the general population were conducted in 11 Member States during the 1990s. These surveys provide useful data on substances such as cannabis, whose use is relatively common and not highly stigmatised, but are less reliable for more hidden patterns of use, such as heroin injection.

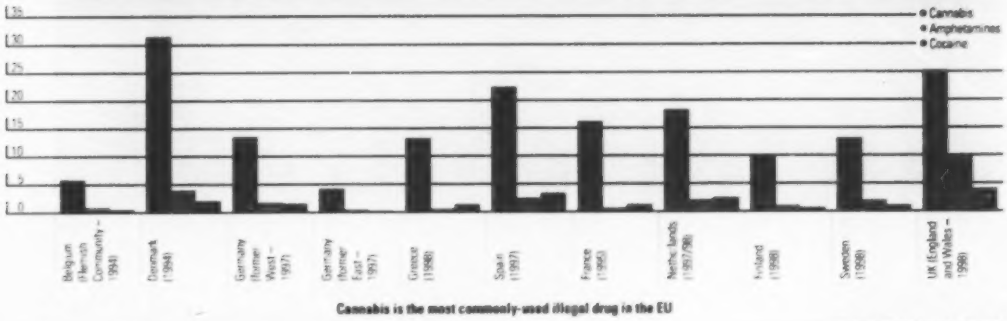
Direct comparisons between levels of use in Member States should be made with caution, especially where variations are small. Social differences (such as level of urbanisation) or cultural factors (including attitudes to drugs) may have a significant influence, even when survey methods are similar.

#### Patterns of drug use

Cannabis is the most frequently used substance in the EU. Lifetime experience (any use during a person's lifetime) in the adult population ranges from 10 % in Finland to 20 or 30 % in Denmark, Spain and the UK (Figure 1). Amphetamines are generally used by 1 to 4 % of adults, but by up to 10 % in the UK. Ecstasy has been tried by 0.5 to 4 % of European adults and cocaine by 0.5 to 3 %. Experience of heroin is harder to estimate because of its low prevalence and more hidden nature, but is generally reported by under 1 % of adults.

Illegal drug use is more concentrated among young adults aged 16 or 18 to 34 or 39, with rates up to double or more those of the whole adult population (Figure 2). In Finland and Sweden, 16 to 17 % of young adults have used cannabis, while in Denmark and the UK the figure is about 40 %. Amphetamines and ecstasy have been tried

Fig. 1 Lifetime experience of cannabis, amphetamines and cocaine among adults in some EU countries measured by national population surveys, 1994-98




**Cannabis is the most commonly-used illegal drug in the EU**

Notes: (1) Data are from the most recent national surveys available in each country.
(2) The age range is from 15 to 18 to 59 to 69. Variations in age ranges may influence disparities between countries.
Sources: Pompidou Group country reports 1999, based on population survey reports or scientific journal articles.



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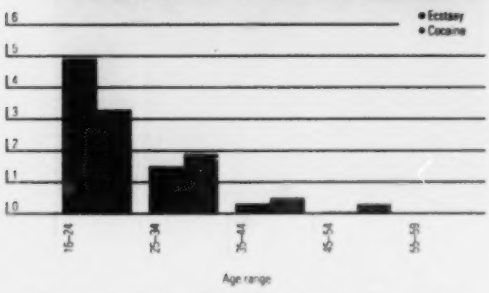
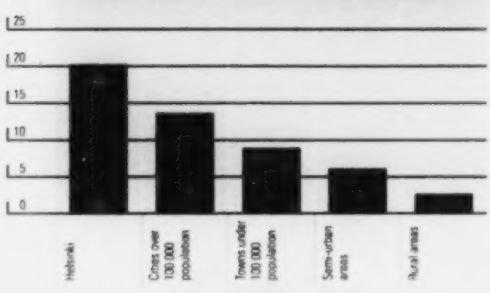
Fig. 2 Last 12 months prevalence of ecstasy and cocaine use by age group in England and Wales, 1998




**Ecstasy and cocaine use is a youthful phenomenon which decreases with age**

*Source:* UK national report 1999, taken from Ramsay, M., and Partridge, S., *Drug misuse declared in 1998: Results from the British Crime Survey* (London: Home Office, 1999)

Fig. 3 Lifetime experience of cannabis among adults in Finland by level of urbanisation, 1998




**Illegal drug use is higher in urban areas**

*Source:* Finnish national report 1999, taken from Partanen, J., and Metso, L., 'Suomen toinen huumeaalto' (the second Finnish drug wave), *Yhteiskuntapolitiikka* (2) 1999

by 1 to 5 % of young adults, although UK figures are 16 and 8 % respectively. Cocaine has been used by 1 to 6 % of young European adults.

Available data from some countries reveal much higher drug use in urban areas, although some diffusion into rural areas may also be occurring (Figure 3). Variations in national figures can be conditioned to a large extent by the relative proportion of a country's rural and urban populations — countries with a high proportion of urban population tend to have higher overall national drug-use figures.

Lifetime experience is a poor indicator of recent drug use since it includes all those who have ever tried drugs, whether only once or some time ago. Use during the previous year (last-12-months prevalence) is a more accurate measure of recent use (Figure 4).

Last-12-months cannabis use is reported by 1 to 9 % of European adults, and by 2 to 20 % (although mostly under 10 %) of young adults. Use of other illegal substances rarely exceeds 1 % among adults and is under 3 % among young adults.

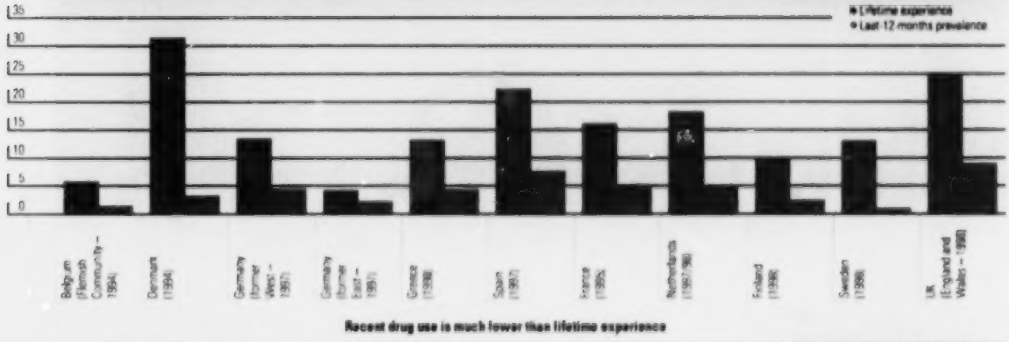
Some surveys indicate that most people who used drugs recently tended to do so occasionally (Figure 5).

**Developments in drug use**

While several countries conducted more than one population survey in the 1990s, only Germany, Spain, Sweden and the UK carried out series of comparable surveys.

Lifetime experience of cannabis increased over the decade in most countries, and levels appear to be converging. Where prevalence was low early in the decade (for example, in Greece, Finland and Sweden), increases have been proportionally greater than where

Fig. 4 Lifetime experience and last 12 months prevalence of cannabis use among adults in some EU countries measured by national population surveys, 1990–98




**Recent drug use is much lower than lifetime experience**

Notes: (1) Data are from the most recent national surveys available in each country.
(2) The age range is from 15 to 18 to 59 to 69. Variations in age ranges may influence disparities between countries.
Sources: Various national reports 1999, taken from survey reports or scientific journal articles.



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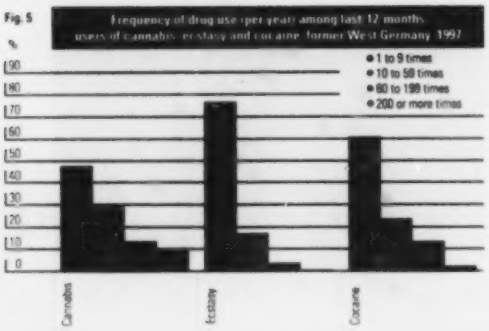
Fig. 5 Frequency of drug use (per year) among last 12 months users of cannabis, ecstasy and cocaine, former West Germany, 1997




The most common illegal drugs are generally used intermittently, rather than frequently

Source: German national report, 1999, taken from Kraus, L., and Bauernfeind, R., *Repräsentative survey on the consumption of psychoactive substances in the German adult population 1997* (Munich: Institute for Therapy Research, 1998). The frequencies were reproduced by the EMCDDA from the original distribution. Percentages expressed as valid percentages, excluding the 'no answer' (cocaine 17.5%, ecstasy 7.2% and cannabis 0.7%).

initial prevalence was higher (for example, in Denmark, Germany and the UK).

Increased lifetime experience of cannabis does not necessarily imply a parallel growth in recent use (Figure 6). Last-12-months prevalence has generally risen much less than lifetime experience, implying that the reported increases are mainly in occasional use and that most experimenters do not seem to continue to use in the longer term.

Trends in use of other substances are more difficult to track because prevalence is lower. Well-documented developments, such as increased recent ecstasy use among groups of young people, become diluted in figures covering the whole population. In some countries, amphetamine, ecstasy and cocaine use increased moderately — but not consistently — over the 1990s as a whole, with ecstasy use more evident than amphetamine or cocaine use among young adults overall.

## Drug use in the school population

School surveys were conducted in most countries in the 1990s, many as part of the European school survey project on alcohol and other drugs (ESPAD). Studies were carried out in 1995 and again in 1999, focusing on lifetime experience of drugs among 15 to 16-year-olds, but direct comparisons should be made cautiously (1). As with adults, lifetime prevalence rates are indicative of experimentation. Apart from methodological and contextual variations, small disparities in age among this group have a major impact on figures.

### Patterns of drug use

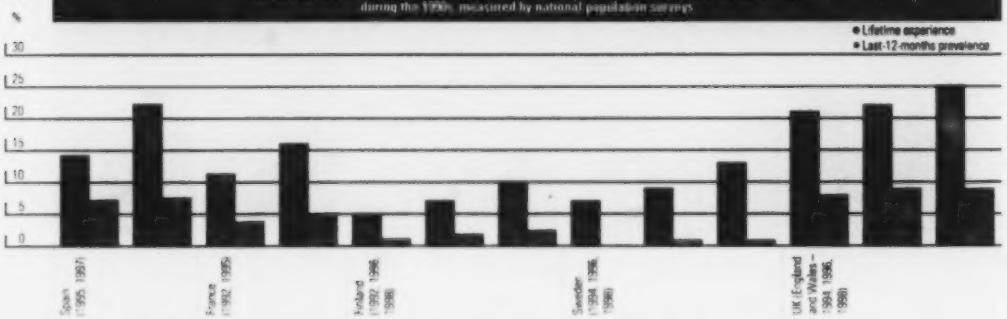
Cannabis is the most widely used illegal substance among schoolchildren. Lifetime experience ranges from 5 to 7 % in Portugal and Sweden to 30 to 40 % in Ireland, the Netherlands and the UK. In some countries, however, solvent use is more common in this age range (Figure 7).

Amphetamine experience is reported by 1 to 7 % of schoolchildren and ecstasy use by 2 to 8 %, while figures for cocaine are between 1 and 4 %. Some UK surveys report higher use of amphetamines and ecstasy.

### Developments in drug use

Lifetime experience of cannabis among schoolchildren increased substantially during the 1990s in almost all EU countries. While use of solvents, amphetamines, ecstasy and cocaine also rose, their prevalence remains much lower than for cannabis.

Fig. 6 Evolution of lifetime experience and recent (last 12 months) use of cannabis in some EU countries during the 1990s, measured by national population surveys

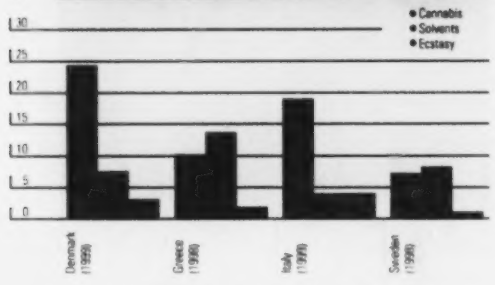



Although increasing numbers of people have tried cannabis, the number of current users is not rising at the same rate

Source: Reitox national reports 1999, taken from survey reports or scientific journal articles.

(1) All figures for schoolchildren presented in this report refer to 15 to 16-year-olds, for consistency with the ESPAD studies. Results of the 1999 study are not yet fully available.

Fig. 7 Lifetime experience of cannabis, solvents and ecstasy among 15 to 16-year-olds in some EU countries, measured by national school surveys




**Among schoolchildren, use of solvents can be more common than use of cannabis**

Notes: (1) Data are from the most recent national school surveys available
(2) The countries presented here illustrate divergent patterns of drug experience among schoolchildren. Other Member States may have higher or lower levels of cannabis, solvent and ecstasy use.

Sources: Reitox national reports, taken from survey reports or scientific journal articles.

## National estimates of problem drug use

### Methodology and definitions

'Problem drug use' is defined here as 'intravenous or long-duration/regular use of opiates, cocaine and/or amphetamines'. This operational definition excludes ecstasy and cannabis and irregular use of any drug. National estimates are for 1996 to 1998 except for Austria (1995) and Sweden (1992), where more recent data were lacking (Figure 8).

Prevalence rates have been recalculated for the 15 to 64 age group, and so are not directly comparable with the EMCDDA's 1999 annual report. Estimates are mainly based on statistical models incorporating drug-related indicators and include:

- a multivariate indicator method;
- capture-recapture;
- three multipliers based on police data, treatment data and mortality rates; and,
- a multiplier method using back-calculated numbers of intravenous drug users (IDUs) with HIV/AIDS in combination with HIV/AIDS rates among IDUs.

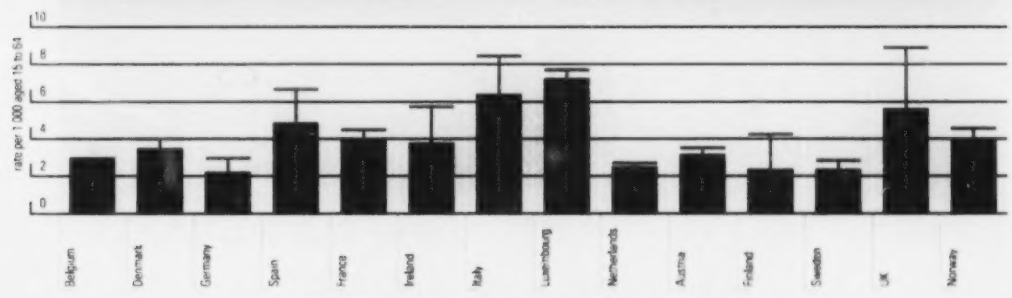
The range in Figure 8 is based on the lowest and highest figures per country obtained by different methods. Techniques do not always refer to the same target group, for example back calculation only covers IDUs. While the lower figure of a range defines intravenous opiate use, the upper figure includes other forms of problem drug use, such as non-intravenous regular consumption of opiates, cocaine or amphetamines.

Italy applied five methods, Denmark, Germany, France, Ireland, Finland and the UK applied three, Spain, Luxembourg and the Netherlands used two, while Belgium, Austria, Sweden and Norway could only apply one. Using several independent methods allows cross-validation of single estimates and could lead to more reliable overall estimates. However, comparing between countries is still not straightforward as most countries could not apply all methods.

### National prevalence estimates

Despite the limitations, prevalence rates seem highest in Spain, Italy, Luxembourg and the UK (about five to seven problem drug users per 1000 inhabitants aged 15 to 64, ranging from 2.3 to 8.9) and lowest in Belgium, Germany,

Fig. 8 National prevalence estimates of problem drug use in the EU and Norway, 1996–98

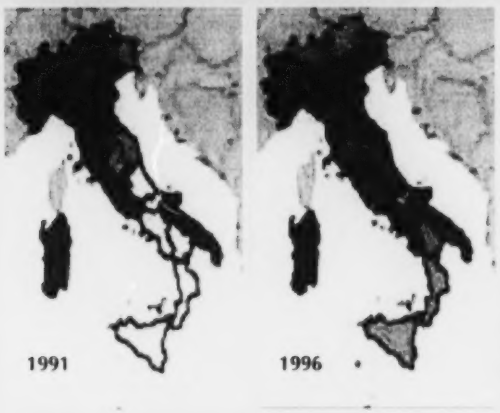



**Prevalence of problem drug use appears to be relatively similar in most countries**

Notes: (1) All estimates are based on a 12-month period between 1996 and 1998, except for Austria (1995), Ireland (1995–96) and Sweden (1992). Greece and Portugal were unable to provide estimates.
(2) Belgium: estimate includes only IDUs and thus underestimates problem drug use; Ireland: the police data included 7% non-opiate users, 10% identified because of possession (not necessarily users) and 5% identified by unspecified means.
(3) Sweden (1992): 1 700 to 3 350 heroin addicts; 8 900 to 12 450 other addicts, mostly amphetamine injectors (excluding cannabis addicts).
(4) Where available, estimates are given as the range of the lowest and highest results from independent calculations. The differences depend on data sources and assumptions; see the statistical tables at www.emcdda.org

Source: EMCDDA project CT.99.RTX.05, coordinated by the Institute for Therapy Research, Munich.

## Geographic spread of problem heroin use in Italy




In Italy, the heroin epidemic led to an increased demand for treatment for problem heroin use during the early 1990s. This demand is indirectly reflected by the prevalence of clients in treatment, which shows a spread from north to south and from border regions to the interior.

By 1996, the epidemic had stabilised and even decreased in regions where it had originally increased rapidly. Prevalence of clients in treatment continued to rise in other areas where it had remained low in the early 1990s.

The geographic spread of problem heroin use in Italy seems to have followed the main drug trafficking routes (for example, from the Balkans via Greece to Puglia), as well as moving out from large cities to smaller towns in rural areas.

*Source:* EMCDDA project CT.98.EP.04, coordinated by Keele University, UK. Map provided by the University of Rome, Tor Vergata.

the Netherlands, Austria, Finland and Sweden (about two to three per 1000, ranging from 0.5 to 5.7). Intermediate rates are reported in Denmark, Spain, France, Ireland and Norway. Portugal and Greece were unable to provide estimates.

These rates suggest little direct association between prevalence of problem drug use and national drug policy, since countries seem to have similar, often moderate, levels of use whether their policies are more liberal or more restrictive. Drug policies may, however, be significant in minimising some consequences of problem use, such as infections and overdoses.

Demographic variables, such as age structure, population density and urban–rural ratios, may also affect prevalence, and socioeconomic factors, like unemployment, education or income, correlate with prevalence levels in some, but not all, studies. Factors relating to geographic diffusion, such as trafficking routes, may also have an influence (see box above).

# Health consequences of drug use

## Demand for treatment

Characteristics of clients entering treatment, such as the proportion of injectors or opiate users, are potential indicators of wider trends in problem drug use. Biases may, however, arise, such as over-representation of injectors because of their greater need for treatment or under-representation of cocaine users because of a lack of treatment services.

### Patterns of drug use among treated clients

Despite differences in treatment policies and recording practices, both common and divergent features are observed across Europe which cannot be attributed to methodology.

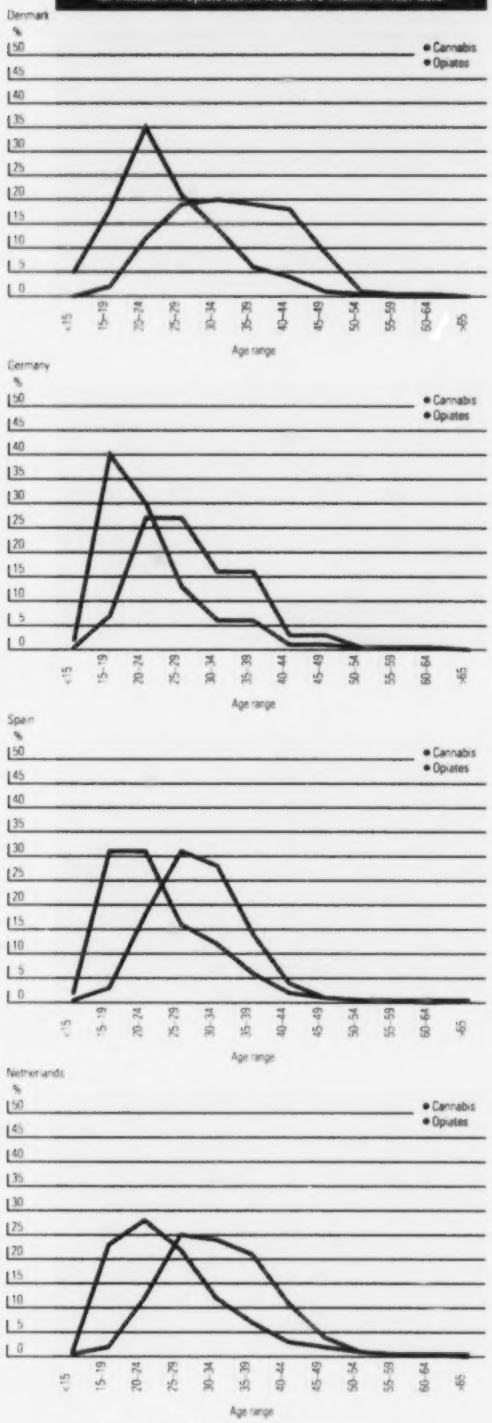
Between 65 and 95 % of clients are admitted to treatment for opiate (mainly heroin) use. Figures are lower only in Belgium's Flemish Community, Finland and Sweden.

Cocaine is the main drug in under 10 % of treatment admissions, except in Spain (11 %) and the Netherlands (17 %). Cocaine is often a secondary drug of clients treated for heroin (15 to 60 % where data are available).

Amphetamines, ecstasy and hallucinogens are the main drug in less than 1 to 2 % of treatment admissions, although figures for amphetamines are higher in Belgium's Flemish Community, Finland, Sweden and the UK.

Cannabis is the primary drug in up to 10 to 15 % of admissions, rising to around 20 % in Belgium's Flemish Community, Denmark and Finland, and is often a secondary drug amongst opiate clients. Cannabis clients are much younger than opiate clients (Figure 9), suggesting groups with different social and personal profiles.

Fig. 9 Age distribution of clients admitted to treatment for cannabis or opiate use in several EU countries (1997 data)




Are we seeing different subpopulations in treatment?

Source: EMCDDA project CT98.EP10, coordinated by the Institute for Therapy Research, Munich

The proportion of injectors among clients in treatment varies markedly, from 14 % of heroin users in the Netherlands to 84 % in Greece. France, Italy and Luxembourg report over 70 % of injectors among opiate clients, while in other countries figures range from 30 to 60 %. Reasons for these differences are not yet clear, but could include local or cultural traditions, or market factors such as the relative availability of smokable or injectable heroin.

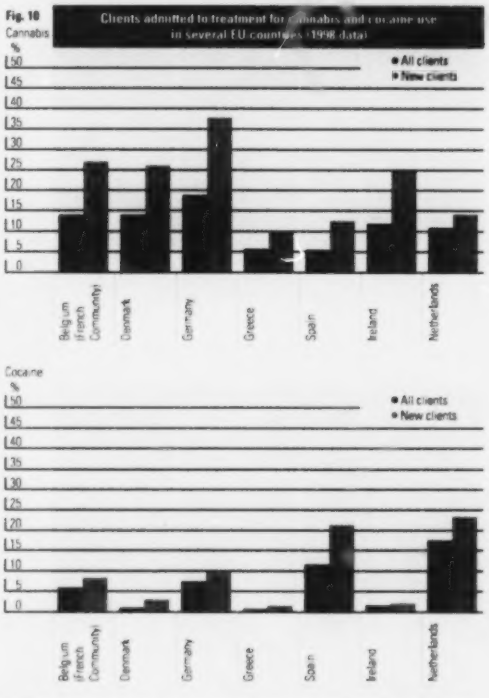
Clients entering treatment tend to be males in their 20s or 30s. Ireland has the lowest mean age (24.3 years) and Denmark the highest (32.5 years).

**Developments in the profile of treatment admissions**

Despite substantial improvements in treatment-data collection, few countries can yet identify consistent trends. Instead, characteristics of first-time clients are often compared to the whole treated population to identify tendencies.

Many Member States report a moderate increase in the proportion of cannabis and cocaine clients in recent years with a parallel decrease in the proportion of opiate cases (Figure 10). The proportion of amphetamine clients is low, but higher amongst new clients. While these varia-

Fig. 10 Clients admitted to treatment for cannabis and cocaine use in several EU countries (1998 data)




Increasing numbers of clients are seeking treatment for cannabis and cocaine use

Source: Pompidou national reports 1999, based on national treatment reporting systems



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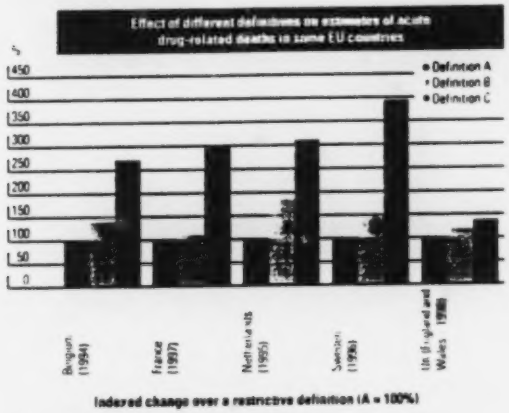
## Effect of different definitions on estimates of acute drug-related deaths in some EU countries

The use of restrictive or more inclusive definitions of drug-related deaths within the same country leads to very different estimates.




Notes: Data are taken from general mortality registries.
Definition A: drug psychosis, drug dependence, non-dependent drug abuse and accidental poisoning caused by use of opiates, cocaine, stimulants, cannabis or hallucinogens.
Definition B: A plus intentional poisoning or undetermined poisoning caused by use of the same drugs of abuse.
Definition C: B plus deaths caused by the use of barbiturates, benzodiazepines, other sedatives and hypnotics.

Source: EMCDDA project CT.98.EP.11, coordinated by the Trimbos Institute, Utrecht.

Definitions A, B and C were developed for methodological purposes as part of EMCDDA project CT.98.EP.11. They refer to cases whose underlying cause of death corresponds to International Classification of Diseases 9th edition (ICD-9) codes. External causes of death (poisoning) were extracted in combination with nature of injury codes to indicate the relevant drug of abuse.

The more restrictive definition A was made equal to 100 % in each country, and the more inclusive definitions B and C were expressed as percentages of A.

Current 'national definitions' of drug-related deaths do not, however, correspond exactly to the A, B or C groups given here. Dutch and UK national definitions, for example, give fairly similar results to definition A, whereas Sweden's definition provides data in between those for definitions B and C. In Sweden, cases are also selected using both underlying and contributory causes of death, and not only underlying causes as in the EMCDDA project. This results in a higher 'national' estimate, since not only acute deaths (overdoses), but also indirect drug-related deaths may be included.

Even when the same set of codes (EMCDDA A, B or C) are applied, population rates may still not be fully comparable due to differences in autopsy rates or the use of forensic information in codifying the death.

Drug-related rates per 10 000, according to definitions A, B and C

| | A | B | C |
|---|---|---|---|
| Belgium (1994) | 0.9 | 1.2 | 2.1 |
| France (1997) | 0.3 | 0.3 | 0.7 |
| Netherlands (1995) | 0.2 | 0.5 | 0.8 |
| Sweden (1998) | 1.5 | 1.9 | 3.6 |
| UK (England and Wales – 1998) | 2.2 | 2.7 | 2.9 |

tions may indicate real developments, the relevance of increases in cannabis and cocaine clients may in part reflect decreases in the number of opiate cases among new treatment clients.

The proportion of injectors among treated heroin users fell in several countries during the 1990s and is not increasing. The proportion of injectors among new heroin clients compared to all heroin clients is also markedly lower in all countries where data are available (Figure 11). New clients more often smoke or 'chase' heroin, and a sizeable proportion who do not currently inject previously did so. While this indicates changing consumption patterns, some smokers may become future injectors.

## Drug-related deaths

### Methodology and definitions

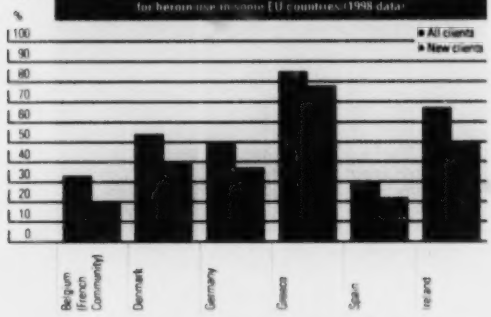
National statistics on drug-related deaths mostly refer to acute deaths directly linked to drug administration ('overdoses'), although Denmark, Germany, Portugal and Sweden use somewhat wider definitions. Deaths indirectly associated with drug use (deaths from AIDS, traffic accidents, violence or suicide) are assessed differently and are not discussed here.

Direct comparisons of drug-related death statistics between countries are, however, misleading because of the lack of harmonised definitions and methodologies. The EMCDDA is collaborating with Eurostat, the World Health Organisation and EU Member States to improve this situation (see box above). If definitions and methods remain consistent within countries, however, the statistics can indicate trends over time.

### Features of drug-related deaths

Opiates are the main drug recorded in most drug-related deaths. The presence of other substances, particularly

Fig. 11 Proportion of injectors among clients admitted to treatment for heroin use in some EU countries: 1998 data



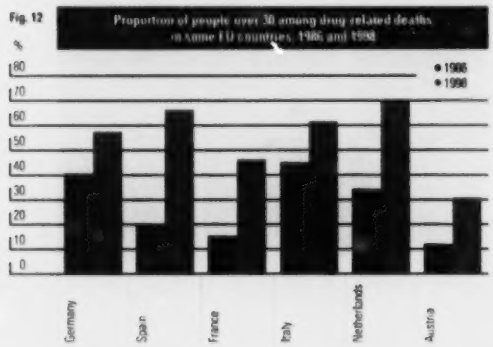

**A decreasing proportion of heroin users entering treatment are injectors**

*Source:* Annual national reports 1999, taken from national treatment reporting systems.

alcohol and benzodiazepines, increases the risk of death in opiate intoxication. Many such deaths occur up to three hours after use, however, making medical intervention possible. Acute deaths related solely to cocaine, amphetamines or ecstasy are unusual, despite the publicity they receive.

Most opiate deaths occur among injectors in their late 20s or 30s, usually after several years of use. As with clients entering treatment, a clear ageing trend is observed among deceased opiate users in many EU countries (Figure 12).

Fig. 12 Proportion of people over 30 among drug related deaths in some EU countries, 1986 and 1998




**A clear ageing trend is evident among drug-related deaths**

Notes: (1) Data for Italy are for 1993 and 1998, and data for Austria are for 1989 and 1998.
(2) Data for Austria refer to those aged 35 to 64, and for Germany to those aged 30 or older.
(3) The proportions were calculated from the total of the younger and older age groups.

*Source:* Reitox national reports 1999, taken from national mortality registries or special registries (forensic or police).

The potential role of methadone in drug deaths has been highlighted in some countries. Research shows that substitution treatment reduces the risks of drug-related death. However, since methadone substitution has increased substantially in Europe (see Chapter 4), toxicological examinations of overdoses, AIDS deaths or accidents increasingly indicate the presence of methadone, regardless of whether there is a causal relationship. Some local studies suggest that acute deaths involving methadone are particularly likely to involve therapeutic methadone that has been stolen or diverted to the illegal market.

### Developments in drug-related deaths

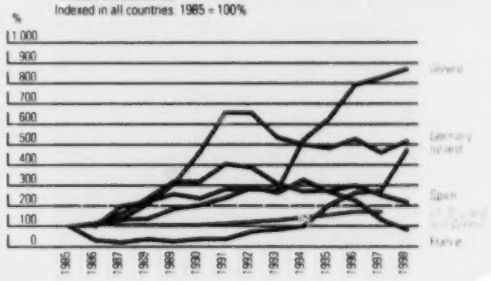
In many countries, acute drug-related deaths increased markedly from the late 1980s to the mid-1990s. This rise has since stabilised in the EU as a whole, but divergent national trends can still be identified.

- In Spain, France and to some extent Germany (although a recent increase was reported), Italy and Austria, acute drug-related deaths have stabilised or decreased. This may reflect levels of problem drug use, reduced injecting and/or increases in access to treatment, including substitution treatment.

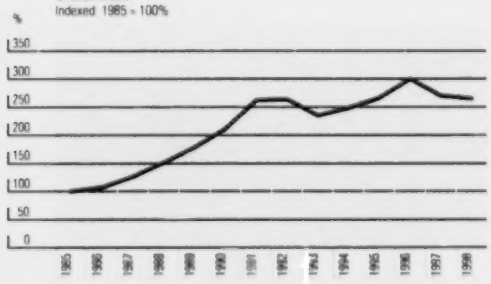
- Following few deaths in the early 1990s, Greece, Ireland and Portugal have since reported substantial increases. These may be related to rising heroin use, but also reflect improved recording practices.

Fig. 13 Trends in acute drug-related deaths 1985–98

**In some EU countries**
Indexed in all countries: 1985 = 100%




**Overall trend**
Indexed: 1985 = 100%




**Acute drug-related deaths have stabilised overall in the EU, despite divergent trends in some countries**

Notes: (1) Only a few countries are presented here to illustrate divergent national trends.
(2) Proportional variations over 1985 figures are presented. For Greece, the series begins in 1988 to avoid distortion.
(3) In some countries with an increasing trend, improved reporting may account for part of the increase.
(4) Not all countries provided data for all years.

*Sources:* Reitox national reports 1999, taken from national mortality registries or special registries (forensic or police).

• Following significant numbers of drug-related deaths in the early 1990s, increases continue in Sweden, the UK and, to some extent, Denmark. The reasons for this tendency need further investigation.

## Mortality among drug users

Assessing mortality and causes of death among problem drug users facilitates the planning and evaluation of public-health interventions and complements drug-related death statistics. Mortality is gauged by following groups of problem users, usually opiate users recruited from treatment settings, over several years (cohort studies).

Results indicate that mortality rates are up to 20 times higher in opiate users than in equivalent age groups in the general population. Among females, rates can be over 30 times higher than non-using women of the same age. These high figures reflect causes such as overdoses, accidents, suicides or infectious diseases. The mortality of injectors is two to four times higher than non-injectors, while that of users infected by HIV is two to six times higher than non-infected users.

Analysis of cohorts in a multi-site study coordinated by the EMCDDA shows substantial differences in mortality and causes of death between locations. In cities with high HIV infection among drug users, the impact of AIDS from the mid-1980s has raised mortality rates. In Barcelona (Figure 14), mortality reached over 50 per 1 000 users per year from 1992 to 1996 before falling markedly, reflecting a drop in AIDS deaths (probably because of new anti-retroviral treatments) and, to a lesser extent, in overdose deaths.

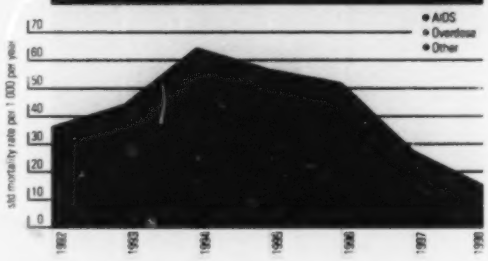
## Drug-related infectious diseases

### HIV and AIDS

Significant differences in prevalence of HIV infection among drug injectors — from 1 % in the UK to 32 % in Spain (Figure 15) — cannot be explained by differences in sources and data-collection methods.

Since the mid-1990s, HIV prevalence seems to have stabilised in most countries after a sharp decline following the first major epidemic among IDUs in the 1980s. However, new infections occur continuously, counterbalancing the decline in prevalence caused by deaths. In some areas, prevalence may even be increasing. In Finland, HIV cases among IDUs have increased considerably since 1998 (not shown in this report). In late 1998, local HIV prevalence in a group of addicts (mostly injectors) in Lisbon was 48 %, higher than in previous studies, suggesting recent transmission.

Fig. 14 Evolution of cause-specific mortality rates in Barcelona among a cohort of drug users recruited in treatment centres, 1992–98

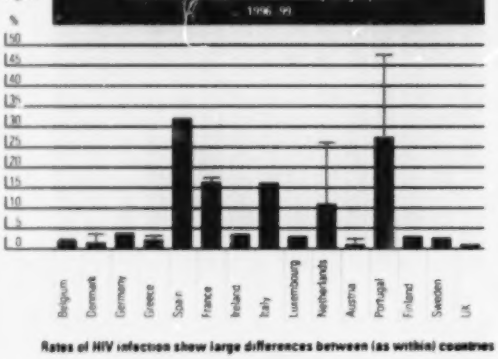



**Mortality among problem drug users varies over time, and can decrease**

Note: Overdoses are defined in this cohort as deaths classified under codes E850.0 to E858.9 of the International Classification of Diseases 9th edition (ICD-9).

Source: EMCDDA project CT.98.EP.12, coordinated by the Osservatorio Epidemiologico Regione Lazio, Rome.

Fig. 15 Prevalence of HIV infection among drug injectors, 1996–99

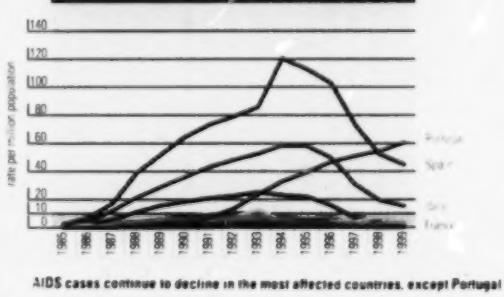



**Rates of HIV infection show large differences between (as within) countries**

Note: Comparability is limited because figures are from different sources and reflect different methods. For methodological notes, see the statistical tables at www.emcdda.org. Figures for Denmark, the Netherlands and Finland and the high figures for Austria and Portugal are local. Figures for Germany and Italy are for opiate users in treatment and underestimate prevalence among IDUs.

Source: For sources, see the statistical tables at www.emcdda.org.

Fig. 16 Incidence of drug related AIDS cases, 1985–99

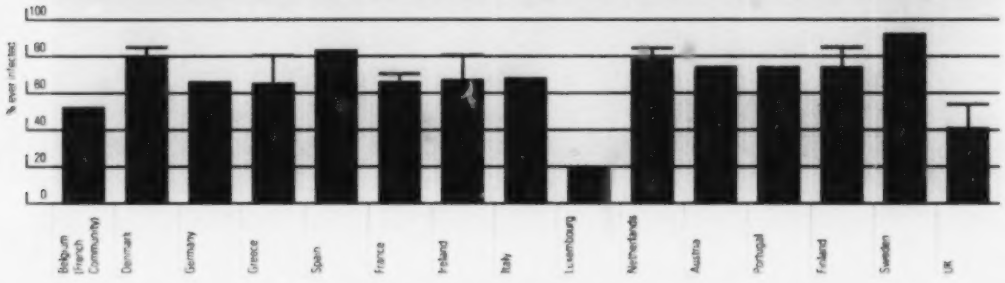



**AIDS cases continue to decline in the most affected countries, except Portugal**

Notes: (1) Figures are adjusted for reporting delays.
(2) In some countries, there may be small differences between the figures reported by the European Centre for the Epidemiological Monitoring of AIDS and national figures due to reporting delays.

Source: European Centre for the Epidemiological Monitoring of AIDS, Paris.

Fig. 17 Prevalence of hepatitis C among drug injectors 1994–99




**Rates of hepatitis C infection among injecting drug users are extremely high**

Note: Comparability is limited because figures are from different sources and reflect different methods, and many are not national figures. Figures for Denmark, Germany, the Netherlands, Austria, Portugal and Finland are local. For methodological notes, see the statistical tables at www.emcdda.org

Source: For sources, see the statistical tables at www.emcdda.org

Incidence of new AIDS cases also varies greatly between countries although the general trend is downward (Figure 16). This decline is probably the result of new treatments that delay the onset of AIDS. In Portugal, rates of new AIDS cases are not falling, possibly indicating low uptake of treatment and/or increased HIV infection rates. The proportion of IDUs among all cumulative AIDS cases also differs significantly between countries, illustrating variations in the relative importance of IDUs in the AIDS epidemic.

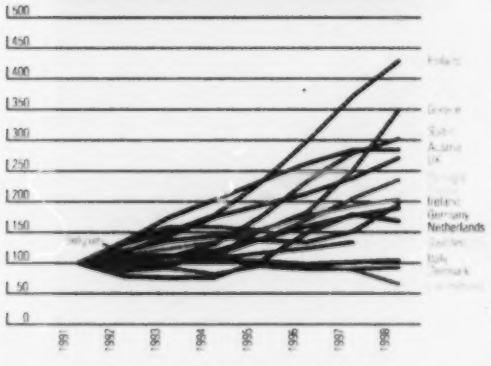
### Hepatitis B and C

Hepatitis C infection in IDUs is more prevalent and uniform across the EU than hepatitis B infection. Whereas prevalence of hepatitis B antibodies is between 20 and 70 %, prevalence of hepatitis C infection ranges from about 20 to over 90 %, even in countries with low rates of HIV infection such as Greece (Figure 17).

In most countries, increased access to sterile needles and syringes, greater availability of condoms, HIV counselling and testing, and substitution treatment have all helped control HIV transmission among injectors. While such measures can also help reduce hepatitis C infection among injectors, they have not prevented its spread. The persistence of hepatitis C infection among new injectors requires innovative responses. An EU-wide surveillance system is also needed.

Few new data on hepatitis B infection are available and thus are not presented here. Prevalence of total anti-bodies is not a satisfactory measure as it reflects vaccination as well as past, current or chronic infection. However, numbers of injectors with no hepatitis B antibodies indicate a population at risk who would benefit from vaccination. Those who remain infectious can be identified using a specific serological marker (hepatitis B surface antigen HBsAg). Data on levels of HBsAg will be included in future annual reports.

Fig. 18 'Arrests' for drug offences 1991–98
Three-year moving averages indexed (1991=100)




**'Arrests' for drug offences are rising in most countries**

Notes: (1) Real values have been input for all countries in 1998 and for Sweden in 1997 since the available data do not allow moving averages to be calculated in these cases.
(2) The series is discontinued for Belgium in 1998 and 1997 as data are not available. The 1998 value should be read as 153.
(3) The 1998 figure for Greece relates to the number of charges made.

Source: Annual national reports 1999

## Law-enforcement indicators

Drug-related data from law-enforcement agencies reflect variations in national legislation as well as in resources and priorities. Although differences in recording procedures and definitions prevent accurate comparison, tendencies are described whenever possible.

### 'Arrests' for drug offences

'Arrests' (2) for all drug offences in Europe have increased steadily since the mid-1980s and markedly since 1994.

(2) Member States define 'arrests' for drug offences in different ways. The term may, for example, refer to suspected offenders or to charges for drug-law offences.

Greece, Spain, the Netherlands, Portugal and Finland report the highest recent increases, while in Denmark and Luxembourg levels have stabilised.

In 1998, cannabis was the most common substance involved in drug-related 'arrests', accounting for 39 % of all such 'arrests' in Ireland and 85 % in France. In Italy, Luxembourg and Portugal, 40 to 60 % of 'arrests' involved heroin, while in Sweden 55 % involved amphetamines, a marginally higher figure than for cannabis. In the Netherlands, most drug-related 'arrests' involve 'hard' drugs (substances other than cannabis).

In all countries that penalise possession and/or use of drugs (3), such offences predominated in 1997 and 1998 — from 61 % of all drug-related offences in Portugal to 87 % in Austria (although this figure includes trafficking in small quantities). In Luxembourg, the majority of 'arrests' involve use and trafficking.

### Prison data

Routine data on drug use in prison are rarely collected, and most information comes from local ad hoc studies. While a high proportion — up to 90 % in some cases — of remand and sentenced prisoners are drug users, numbers of problem drug users are lower, ranging from 20 to 50 % of the total prison population in most Member States.

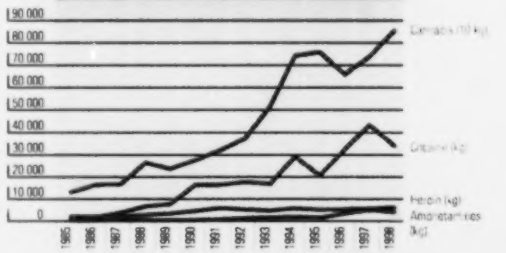
### Drug use in prison

Studies report drug use within prisons in most EU countries (4). Some prisoners start using drugs in prison. Initiation of injecting drug use in prison has also been reported. Although injecting seems to be less frequent inside prison than outside, up to 70 % of injectors in some prisons share needles and other injecting equipment.

## Drug-market indicators: seizures, price, purity

While drug seizures may indirectly indicate drug supply and availability, they also reflect law-enforcement priorities and strategies, as well as the likelihood of different drugs being seized. Quantities seized (Figure 19) are difficult to analyse since they may fluctuate following a few exceptionally large seizures. The number of seizures (Figure 20), which in many countries includes a major proportion of small seizures from the retail level, may more accurately indicate trends in availability on the domestic market. Seizure data should be analysed alongside other market indicators such as price, purity, availability and market structure. These data are still very scarce at national level, making an accurate picture of the drug market difficult to draw.

Fig. 19 Quantities of cannabis, cocaine, heroin and amphetamines seized, 1985–98




**The quantities of cannabis and cocaine seized increased markedly in the 1990s**

Notes: (1) Where data are not available, figures are under estimates.
(2) Data on cannabis seizures in 1998 for Belgium are not available.
(3) Data on amphetamine seizures from 1996 to 1998 for Belgium are not available and in 1998 for Austria.

Sources: Reitox national reports, 1999.

### Cannabis

In all EU countries except Portugal, cannabis accounts for the greatest number of seizures. Since 1985, the number of cannabis seizures increased steadily, and more sharply since 1997. The quantities involved have also risen — despite a fall in 1996 — peaking at 853 tonnes in 1998. In 1998, Spain remained the country seizing the largest amount of cannabis, although the UK reported twice the total number of seizures made in Spain.

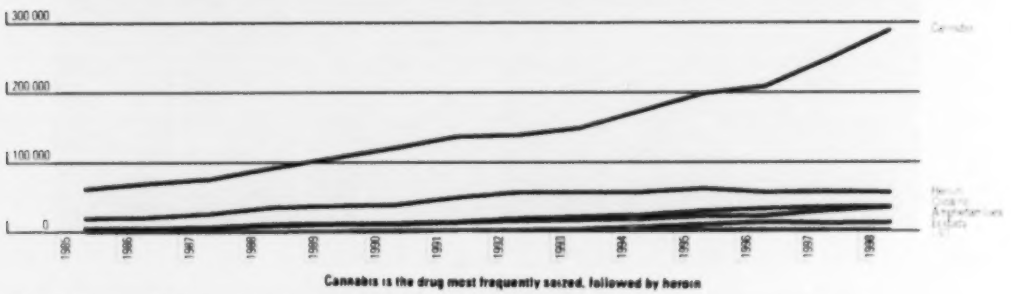
Cannabis prices are generally stable throughout the EU. In Germany, the strength of cannabis as measured by the percentage of the psychoactive substance delta-9-tetrahydrocannabinol (THC) ranged from less than 3 to 20 % in 1998 with nearly half of the hashish samples analysed containing 6 to 9 % THC.

### Heroin

Following increases from 1985 to 1991–92, both the number of heroin seizures and the quantities involved have stabilised throughout the EU, with some variations between countries. The number of seizures has decreased markedly since 1995 in Denmark, Germany, France, Italy, Luxembourg and Austria, but has increased in Ireland, Finland, Sweden and the UK. The quantities of heroin involved have also fluctuated, with decreases in Germany, France and Finland in the last three years. In 1998, the Netherlands seized one third of the total amount of heroin in the EU, while the UK, followed by Spain, reported the highest number of seizures.

(3) Data were not available for Denmark or Italy.
(4) For sources, see the statistical tables at www.emcdda.org.

Fig. 20 Number of cannabis, heroin, cocaine, amphetamine, ecstasy and LSD seizures, 1985-'98




Cannabis is the drug most frequently seized, followed by heroin

Notes: (1) Data are not available for Greece; data are only available from 1988 for Denmark and Portugal, from 1987 for the Netherlands and from 1993 to 1996 for Finland.
(2) Data on amphetamine seizures are not available from 1996 for Belgium, and for 1998 for the Netherlands and Austria.
(3) Most of the data series for ecstasy seizures begin in the early 1990s except for Spain, France, Italy and the UK. Data are not available for 1996 and 1997 for Belgium, and for 1998 for the Netherlands; 1998 data for Belgium include amphetamines. The number of ecstasy seizures is over-estimated from 1985 to 1994 since LSD seizures are also included in the figures for Spain.
(4) Data on LSD seizures are not available for 1998 for the Netherlands and Finland.

Sources: Reitox national reports, 1998.

The street price of heroin appears to be remaining constant in Belgium, Ireland and Luxembourg and is stabilising following a decline in Germany. Spain and the UK report increased availability of cheaper heroin, particularly 'brown', smokable heroin in the UK.

Heroin purity ranges from under 20 % in Germany and Greece to 35 to 40 % in Ireland and the UK. Denmark reports average purity of over 60 %.

## Cocaine

Cocaine seizures in the EU continued to increase in 1998 to a total of 35 060. This trend is evident in almost every Member State, but is especially clear in Spain, Ireland and the UK. The quantities involved fluctuate, although the general trend is upwards. Compared to 1997, the total amount of cocaine seized in the EU in 1998 decreased by 21 % to 34 tonnes, mainly reflecting falls in Spain and Portugal. In 1998, the largest amounts were seized in Spain and the Netherlands.

The price of cocaine is generally stable in the EU, but falling in Germany and the UK. Retail purity is between 50 and 60 %, except in Greece where it ranges from 5 to 10 % and Ireland which reported 38 % in 1998.

## Amphetamines, ecstasy and LSD

After a steady increase since the mid-1980s, the number of amphetamine seizures in the EU levelled off in 1998 at about 35 000, with more than half of these in the UK. The Netherlands and the UK account for the greatest quantities of amphetamines seized, although a 45 % decrease in the amounts found in the UK in 1998 caused the EU total to fall by 19 % to around four tonnes. In Finland, Sweden and the UK, amphetamines are the second most commonly seized drug after cannabis.

Following a steady rise since seizures were first reported in the late 1980s to mid-1990s, the number of ecstasy seizures fell or stabilised in most Member States in 1997 and 1998. The numbers of pills found increased markedly to a peak of 9.9 million in 1996 before falling to 4.2 million in 1997 and rising again to 6.2 million in 1998. The largest quantities were found in the UK, followed by the Netherlands and France.

Both the numbers of lysergic acid diethylamide (LSD) seizures and the quantities involved increased to 1993 but have since decreased overall, despite fluctuations in most countries. LSD is less commonly seized than amphetamines or ecstasy.

The prices of both amphetamines and ecstasy decreased in the latter 1990s, but now appear to be stabilising in some Member States.

Amphetamine purity ranges from 6 % in Ireland to 100 % in Greece. By contrast, the composition of pills sold as 'ecstasy' varies considerably. While most contain MDMA or similar substances (MDEA, MDA), they may also include, or consist entirely of, other active ingredients such as amphetamines or caffeine. The physical characteristics of the tablets often do not indicate their composition since the same shape or logo may be used for different contents.

Chapter 3

# Responses to drug use

This chapter presents an overview of developments in national and EU drug policies and strategies and discusses the issues of quality assurance associated with them. Responses to the drug problem in the fields of education, health, social care and criminal justice are also assessed.

## Policy and strategy developments

### National drug policies

National drug policies are becoming more balanced in approach, with greater emphasis placed on demand reduction relative to supply reduction. Prevention and reduction of drug-related harm are the most common elements, and the recently adopted strategies of Spain, France, Portugal and the UK — as well as the European Union itself — demonstrate a trend towards viewing the drug problem in a broader context encompassing issues of poverty, unemployment and social exclusion.

The key elements of these drug strategies are:

- scientific analysis and evidence as a basis for decision-making;
- clear priorities and common objectives;
- performance targets to assess progress; and
- evaluation to measure the strategy's effectiveness.

Coordination at national, regional and local levels is fundamental, and national coordinators both manage and assume political responsibility for implementing policy. In Germany, Italy and Luxembourg, as priority has shifted from repressive policies towards prevention and care, responsibility for drug policy has moved from the Ministries of the Interior to the Ministries of Health and/or Social Affairs. Drug services are increasingly integrated into the health-care, social and criminal-justice sectors, and networks between policy-makers and practitioners at local level and between national, regional and local authorities also enhance cooperation.

The new elements of Germany's addiction policy, adopted in February 2000, focus on reducing drug-related harm and assisting very deprived drug users, for instance by providing a legal framework for injection rooms. Spain's 2000–08 strategy on drugs, adopted on 17 December 1999 by cross-party agreement, prioritises prevention by establishing performance targets, providing for new monitoring centres in the autonomous regions and creating local action plans. The French three-year plan (1999–2001), adopted on 16 June 1999, targets young people through evidence-based prevention, public information, training, treatment and new prosecution guidelines. Portugal's new strategy, approved on 22 April 1999, emphasises prevention, treatment and social rehabilitation. The UK's 1998–2008 strategy targets young people's drug use, access to treatment, crime reduction, and availability/supply of drugs. The policy aims to cut young people's access to drugs by 50 % by 2008, and to reduce drug-related expulsion from schools and absenteeism or dismissal from the workplace. In addition, drug-related deaths are targeted to fall by 25 % by 2002.

Spain and France include both legal and illegal drugs in their new strategies, emphasising the addictive behaviour not the substance. This tendency has been apparent, for example in German, Austrian and Swedish prevention policies, since the 1980s. The Dutch National Drug Monitor, established by the Ministry of Health, which began overseeing drug-related issues in 1999 under the auspices of the Netherlands Institute of Mental Health and Addiction, has competencies in both illegal drugs and alcohol.

In prosecuting drug-related offences, alternative measures to prison are favoured in all Member States if a custodial sentence is not strictly necessary. In parallel, depenalisation of drug-use offences is becoming increasingly common. These trends suggest a consensus that prison is not an appropriate solution for individuals with drug problems. Instead, treatment appears to be the preferred response, even when the severity of the crime makes imprisonment inevitable.

A 1998 Belgian directive stipulated that the possession of cannabis products for personal use should be accorded the 'lowest priority' in criminal justice. Similarly, a June 1999 directive of the French Minister of Justice recommended prosecutors to deliver verbal warnings and cautions rather than imprisoning drug users — especially occasional users of cannabis — who had committed no other related offences. In Germany, debate on the legal status of cannabis has intensified following the request of the Federal Constitutional Court in 1994 for uniform criteria for prosecuting or not personal use of cannabis. In March 2000, the UK government announced the start of scientific trials into cannabis prescription, the results of which are expected in 2002.

A bill is currently under discussion in Luxembourg to depenalise use and possession for personal use of 'reduced-risk' substances, such as cannabis. Portugal's strategy also allows for depenalising drug use or possession for personal use [5], with offences incurring administrative sanctions (such as fines, confiscation of a driving licence or passport), as introduced in Spain in 1992 and Italy in 1993.

**Crime prevention**

France's three-year plan targets drug trafficking, especially in synthetic drugs. In 1999, the Netherlands attempted to increase control of illicit trafficking at national borders, simultaneously lengthening sentences for cannabis dealing and prohibiting indoor cultivation of cannabis plants. In Ireland, a Crime Council was set up in 1999 to help define, inter alia, drug-related crime-prevention policy. The same year, the Criminal Justice Act imposed a minimum mandatory sentence of 10 years for possession of drugs worth over EUR 12 700, although addiction could be a mitigating factor. In Finland, a 1999 proposed amendment to the Police Act recommended new technology for undercover operations and technical surveillance via telecommunication systems.

Drug-related public-order disturbances, property crimes, aggression and violence are of growing concern. An evaluation of Dutch nuisance policy called for broader measures targeted at heavy drug users as well as at 'clubbers' and the homeless.

**Drug supply in prison**

A June 1999 amendment to Finland's Act on the Enforcement of Punishments increased the powers of prison authorities to control drug smuggling by allowing drug tests to be carried out on prisoners suspected of narcotic offences or of being under the influence of drugs who receive unmonitored visits. Also in 1999, the UK introduced measures to prevent drugs being smuggled into prisons and young-offender institutions by banning any visitors found with drugs.

## European Union Drugs Strategy (2000–04)

The European Union Drugs Strategy (2000–04), approved by the Helsinki European Council on 1 December 1999, identifies six major objectives to be achieved over five years:

- to reduce significantly over five years the prevalence of illicit drug use, as well as new recruitment to it, particularly among young people under 18 years of age;
- to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C, tuberculosis) and the number of drug-related deaths;
- to increase substantially the number of successfully treated addicts;
- to reduce substantially the availability of illicit drugs;
- to reduce substantially the amount of drug-related crime; and
- to reduce substantially money-laundering and illicit trafficking in precursors.

Strengthening cooperation among Member States to enhance the provisions of the Treaty of Amsterdam, which entered into force in May 1999, and to develop effective EU-wide law enforcement is also stressed.

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[5] When an offence has been depenalised, penal sanctions can no longer be applied in response to it. Instead, the offence is subject to administrative sanctions, such as fines, or other limitations of certain rights, such as the suspension of a driving licence or the confiscation of a passport. In Portuguese, the term 'decriminalisation' ('descriminalização') has the same meaning as 'depenalisation' ('despenalização') in the sense that it is used in this report.



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The document places great emphasis on evaluation and calls on the EMCDDA to assess the strategy's implemetation. For the EMCDDA, this task will be complicated by the fact that baseline figures are incomplete and some countries do not have the data-collection or evaluation mechanisms in place to collect reliable information.

### Quality assurance

The importance of monitoring the evolution of drug problems and establishing indicators of the delivery and impact of strategies is increasingly recognised, as reflected in the recent Spanish, French, Portuguese and UK action plans, as well as in the EU strategy. In Belgium and Luxembourg, evaluation of the national strategy is ongoing, while a governmental commission will assess Sweden's national drug policy by the end of 2000.

Investment in evaluation research and training is increasing across Europe. Formal quality-assurance procedures to improve the effectiveness of drug prevention and treatment — introducing accreditation schemes, monitoring progress and providing training — are being established in Germany, the Netherlands, Austria and the UK. Most current evaluations concern individual prevention and treatment programmes, but taken together they could form the basis for more sophisticated meta-analyses.

Training for prevention and treatment specialists, but increasingly also for non-specialists in contact with drug problems — primary-health staff, pharmacists, teachers, youth workers, the police, prison staff and voluntary workers — has been intensified in many countries.

Information exchange is a prerequisite for informed decision-making both within and between Member States. To this end, national and regional networking is expanding, as is use of national web sites and databases and multinational projects such as Prevnet involving the Netherlands, Finland and the UK. The EMCDDA's exchange on drug demand reduction action (EDDRA) database, available at www.emcdda.org, is increasingly acknowledged as an instrument of quality assurance.

Major gaps in drug research still exist in all Member States and more funding is clearly needed in this area. Addiction research programmes have recently been launched or are being planned in Germany, the Netherlands and Finland, and new professorships have also been created in Germany, the Netherlands and Sweden to improve the scientific basis of drug policies.

## Demand-reduction responses

### Prevention

**Drug prevention in schools**

Drug prevention in schools is a priority in all Member States. Programmes combining information with training in life skills such as self-assertiveness are increasingly being established. Peer-group approaches actively involving young people in the implementation of activities in their schools are also gaining ground in Denmark, Italy, Austria and Sweden. Evaluations in Greece, Spain and the Netherlands show that with proper training for teachers and adequate support by parents and the wider community such prevention initiatives are effective, at least in the short to medium term.

Guidelines have been drawn up in Germany, the Netherlands and the UK proposing appropriate ways for schools to deal with students with drug problems. Truancy and expulsion or suspension are undesirable since children who are not in school are more at risk of using drugs.

Aside from providing information, activities targeted at parents prioritise interpersonal and communication skills. Some of these programmes are led by professionals, while others promote dialogue between parents. Although evaluation of these initiatives tends to be poor, Danish, German and Greek studies revealed that over 50 % of participants claimed their parenting skills had improved.

In the context of reducing social exclusion, Ireland and the UK have introduced outreach programmes to strengthen socially vulnerable families. These initiatives are fairly new and evaluations are not yet available.

The Internet is increasingly used as a drug-prevention medium with youth web sites providing information and 'chat rooms' on drugs issues, as well as advice for parents. Teachers can also download guidelines from the Internet and exchange experiences through newsgroups.

**Drug prevention in recreational settings**

Youth workers in recreational settings such as youth centres and sports clubs are increasingly required to be able to intervene early if drug problems become evident. In Germany in 1999, 1 500 youth workers based in sports clubs attended specialist drug-prevention seminars. In Belgium, Germany, France and the Netherlands, while observing the overall policy of abstinence, youth workers may advise experimental users in low-risk drug practices to reduce the possibility of their drug use escalating. Assessing the outcome of these programmes is difficult

since the objectives and target groups vary over time. More questionable in terms of effectiveness and sustainability are one-off events such as youth fairs or exhibitions which have increased in the last few years.

'Recreational' drug use by young people throughout the EU continues to move away from large dance events to more geographically diverse clubs and bars and to private parties. Providing information remains the most common prevention measure across the EU, followed by on-the-spot counselling, outreach work and crisis intervention. Users of synthetic drugs, who often consider themselves knowledgeable about drugs and do not perceive that their drug use may be problematic, are seldom seen by traditional drug services and personal interventions and outreach work seem more suited to their needs. A separate counselling centre for synthetic drug users is under consideration in Austria.

Night-club and disco staff can also play a key role in drug prevention, and guidelines on dealing with drug issues — as well as proposals for drug-prevention policies — have been issued to club and bar staff in Ireland, the Netherlands and the UK.

On-the-spot pill testing has been implemented in different forms in Germany, France, the Netherlands and Austria. Analyses of tablets sold on the 'recreational' drug market have revealed that up to 19 % contain substances such as caffeine or ephedrine or no active substance at all. Often, however, pill-testing projects operate in a legal 'grey zone', since removing, analysing and storing illegal drugs, even for test purposes, is a violation of the law. In Austria, pill testing is being carried out as a research study. In the Netherlands, criteria for good testing practice have been developed clearly distinguishing the monitoring from the harm-reduction function.

**High-risk groups**

Those at high risk of drug use include ethnic minorities, socially deprived and/or homeless young people, institutionalised youths and young offenders, and sex workers. Comprehensive child and youth policies are increasingly being developed at local level, and cross-sector coordinating bodies — with financial support, methodological advice and training from central or regional sources — are encouraged to implement action plans based on the needs of their communities. In Denmark, Spain, Ireland, Finland and the UK, drugs issues are tackled in tandem with social exclusion, petty crime, violence and public nuisance.

The long-term nature of these projects is implicit in their design and a key challenge is to sustain the necessary level of cooperation. Evaluation of these community activities is only just beginning, and school attendance figures, police statistics and drug-treatment data can also help to assess their effectiveness.

Specific projects targeting new young drug users are found in all Member States. As these users often experience health, educational, criminal and social problems, many different services are involved and cooperation among them is vital. Early detection of patterns of new drug use and new risk groups is also essential.

Street workers or mobile units often target young, experimental problem drug users in the locations where they congregate. In Greece and Finland, late-night cafes or other meeting places have been set up for, or are even run by, young people at risk. These forms of outreach work are extremely difficult to assess, since objectives, methodologies and actors are often not clearly defined due to the inherent complexity of the task. Evaluation methodology for outreach work is urgently needed and the EMCDDA is developing guidelines to bridge this gap.

## Reducing the harmful consequences of drug use

**Infectious diseases**

The emergence of HIV in the 1980s led to the introduction of syringe-exchange programmes which are now established in all Member States, although to varying degrees. Needle-sharing seems to have decreased in most countries, with more syringes being exchanged. These programmes were given greater priority in Finland in 1999 following a significant increase in HIV infection. In Belgium, Spain and Finland, pharmacists receive special training in health counselling related to syringe-exchange programmes. In, for example, Spain and France, pharmacies fulfil the role of 'low-threshold centres', distributing both syringes and substitution substances.

Data show high prevalence of hepatitis C in Europe, even in countries with low rates of HIV infection. Not only intensifying needle and syringe exchange, but also educating users not to share any injecting equipment, or not to inject at all, are the only currently available preventive measures. A recent trial to provide interferon in a low-threshold setting in Austria has not proved successful.

A hepatitis B vaccination programme in Austria, however, has proved successful, and Germany and the Netherlands report positive experiences, including among those at high risk of intravenous drug use.



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Concerns have been expressed about falling risk awareness and increased risk behaviour among young injectors who may not have benefited from education campaigns following the upsurge of HIV in the late 1980s and early 1990s. Research published in 1998 reveals that efforts in the UK to make IDUs aware of the dangers of encouraging non-injectors to begin injecting have been effective.

**Outreach work and low-threshold services**

Over the past decade, outreach work and low-threshold services assisting drug users who are not yet or no longer in treatment have been introduced as a complement to conventional drug-treatment centres. These services aim to prevent further deterioration in users' health and social circumstances and to motivate them to seek treatment.

Mobile outreach units provide information, clean needles and syringes, first aid, crisis intervention and services in locations where drug users meet or to specific target groups, such as sex workers. In France, Ireland and the Netherlands, such mobile units may also provide methadone.

Low-threshold services are increasing in all Member States — although they have only recently been introduced in Greece and Finland in response to growing concerns about deprived drug users — and attracting growing numbers of visitors. Depending on the specific needs of the users and the available resources, low-threshold services provide food, drink and hygiene facilities, psycho-social and medical support, clean needles and syringes, sleeping facilities and sometimes methadone.

Outreach work and low-threshold services are also provided by organisations run by former drug users whose advice is trusted by current users. The more established user organisations — such as Mainline in Amsterdam or Brugerforeningen in Copenhagen — work with official care services and implement specific projects, for example targeting female users.

**Users' rooms**

Users' rooms provide an environment in which drugs can be consumed under hygienic and supervised conditions, thus reducing the transmission of infectious diseases and the risk of fatal overdoses. Although users' rooms have been established in four German cities since 1994, they only acquired legal status on 25 February 2000 when the narcotics law was modified and a framework regulation was introduced providing minimum standards for equipment and management. The regulation leaves the final decision to each federal state. By contrast, such locations have existed for several decades in the Netherlands. An injection room is due to open in Madrid in 2000 and decisions are pending in Luxembourg and Austria. A study, funded by the European Commission, is currently examining if and how users' rooms reduce risk behaviour, improve and maintain health and relieve the pressure on local communities caused by open drug scenes.

**Prison settings**

Conditions of drug use in prisons are even more conducive to the spread of infectious disease than conditions outside. In 1999, the Spanish Penitentiary Institution recommended that syringe exchange be available in all prisons in an attempt to lessen the dangers caused by needle sharing. 6.6 % of Spain's prison population also receive anti-retroviral treatment. A project to reduce the transmission of infectious disease, including syringe exchange, has been implemented in some German prisons.

## Treatment

**Early stages of drug career**

The numbers of those seeking treatment for amphetamine, cocaine and cannabis use, as well as heroin smoking, has risen throughout the EU. This poses a challenge for conventional drug services that are often inadequate to treat new drug-use patterns at an early stage. Cooperation with youth and social services as well as with psychiatric services has increased, for example in Germany, the Netherlands and Austria. In the UK, 1999 guidelines for treating young people under 16 and between the ages of 16 and 18 have been published.

Interventions targeted at ethnic minorities and immigrants have received attention in Germany, Luxembourg and the Netherlands in the last five years. Drug use is fairly prevalent in some ethnic sub-groups which make little use of drug services either because of language problems or cultural taboos. Promising alternatives include peer approaches involving ethnic associations, and providing information in appropriate language(s). Studies into this issue are under way among the gypsy population in Spain, the Portuguese population in Luxembourg and the Moluccan and North African population in the Netherlands.

**Problem drug users**

In all countries, drug services are dealing increasingly with multiple-drug use. In Denmark, 75 % or more of those admitted to treatment use several drugs. Germany reports problem use of substitution substances such as methadone and codeine (substitution treatment is discussed in detail

in Chapter 4 and is not considered here).

It is not clear how drug services react to these new challenges. National reports suggest that general psychosocial and sometimes psychiatric treatment are the preferred methods, although no country provides very specific information on the methods or objectives of treatment. Greece, Austria and Finland report a growth and diversification in treatment services over the reporting period, and Luxembourg and Portugal are planning similar expansion. France's three-year drugs strategy stresses the importance of linking treatment services for alcohol and illegal drug use. Dutch research from 1998 and 1999 indicates that combining treatment facilities (stepped care, including aftercare) can have positive effects on addiction and criminal recidivism. The long-term, large-scale UK national treatment outcome research study (NTORS) reveals that after two years, both drug-free and methadone treatment led to substantially higher abstinence rates, less frequent use among those still using, with only about one fifth of the sample remaining daily opiate users.

Dual diagnosis — the coincidence of drug and psychiatric problems — is increasingly perceived as a problem in Denmark, the Netherlands and Sweden. Similarly, the problems of ageing drug users with very poor health and often psychological as well as social problems have to be taken into account in countries with a long history of problem drug use, such as the Netherlands and the UK. In response to their increasingly significant role in a diversified care system, guidelines for general practitioners and other public-health staff working with problem drug users have been issued in the Netherlands and the UK.

**Treatment alternatives to punishment**

In general, all Member States agree that drug users should not be imprisoned because of their addiction. A variety of alternatives to punishment are therefore being implemented across Europe, ranging from performing community tasks to outpatient or in-patient treatment (for further details, see Chapter 4). Several studies to evaluate these measures are under way.

**Treatment in prison**

In all EU countries, treatment is available for drug-using prisoners, and in Spain, Germany and Austria use of methadone substitution treatment in prison is growing. Evaluations of drug treatment in prisons, however, are not consistent. Some report substantial decreases in both drug use and crime, while others state that more differentiated studies are needed to come to valid conclusions. Obstacles to effective treatment in prisons include overcrowding, lack of training of prison staff — although specialist training is available in, for example, Spain and Italy — and lack of follow-up after release from prison.

**Reintegration**

Drug users who have been in prison, undergone treatment or are in long-term substitution treatment often lack basic education, professional training, employment and housing, all factors which severely impair their rehabilitation. Greece, Spain, Ireland, Austria, Portugal and Finland have intensified their efforts to assist drug users to (re)-integrate into society and stabilise their lifestyles.

Germany, Greece, Spain and Ireland provide both basic education and professional training courses in crafts, farming or computer skills. Germany, Greece, Spain, Ireland, Austria and Portugal report subsidised employment programmes for (former) drug users, either as specific projects to promote integration into the labour market or as subsidised employment schemes. The European Commission's Integra programme supports the rehabilitation of young people through training and labour policy. Greece, Spain, Austria and Portugal are increasing housing initiatives for (former) users, either in supported accommodation, ordinary flats or with families.

Evaluation of these aftercare programmes has been promising and drop-out rates are low. Maybe even more than for those leaving drug treatment, support for drug-using prisoners on release is essential, both in order to avoid overdoses and to promote social integration.

Chapter 4

# Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: substitution treatment; prosecution of drug-related offences; and the problems facing women drug users and their children.

## Substitution treatment

Substitution treatment first appeared in the EU in the late 1960s in response to emerging opiate use. As such use spread, so too did substitution services, even though their practice varied — and still varies — considerably. Related legislation, prescribing practices and the overall organisation of substitution services also differ substantially within the EU.

Drug users in substitution treatment are prescribed a 'substitute' substance either similar or identical to the drug normally consumed. A distinction is made between detoxification — gradually reducing the quantity of the drug until there is zero intake — and maintenance — providing the user with a sufficient amount to reduce risk behaviour and other related harm over a longer period. Heroin (or other opiate) users are the primary clients, with non-opiate users more often prescribed substitution substances for detoxification purposes. This section focuses exclusively on treatment for opiate addiction.

### Substitution substances

Substitution substances are either agonists — which activate opiate receptors in the brain thus creating the effect of drug consumption — or agonist-antagonists — which while also activating opiate receptors in the brain simultaneously limit or eliminate the effects of other opiates or opioids taken in addition. Some substances, like buprenorphine, combine both agonistic and antagonistic features. Substitution substances used to treat heroin abuse are either opiates — substances derived from the opium poppy such as morphine or codeine, as well as heroin produced from morphine — or opioids — synthetic substances with opiate-like effects, such as buprenorphine or methadone.

Different substitution substances work for different periods of time, and this affects how they are administered. The longest-lasting substance is laevo-alpha-acetyl-methadol (LAAM), which can be taken as little as three times a week. Slow-release morphine can be given every other day, whereas methadone and Mephenon[R]

**Table 1** Substitution substances used in the EU

| Substitution substance | Characteristics of the substance | Countries reporting use of the substance (*) | Estimated average price per week of treatment (EURX[b]) | Substance used for detoxification or maintenance |
|---|---|---|---|---|
| Buprenorphine | Very long-acting agonist-antagonist opioid | Belgium, Denmark, France, Italy, Austria, UK | 85 | Both |
| Dihydrocodeine | Short-acting, semi-synthetic, weak agonistic opioid | Belgium, Germany, Luxembourg | 40 | Both |
| Heroin | Short-acting, strong agonistic opiate | Netherlands, UK | 200 | Maintenance |
| LAAM | Very long-acting, synthetic agonistic opioid | Denmark, Germany, Spain, Portugal | 45 | Both |
| Mephenon[R] | Long-acting, synthetic agonistic opioid | Luxembourg | 8 | Both |
| Methadone | Long-acting, synthetic agonistic opioid | All EU Member States | 20 | Both |
| Slow-release morphine | Long-acting agonistic opiate | Austria | 40 | Both |

Notes: (*) Substitution substances reported in less than 20 cases are not included here.
(**) Maintaining a user at: 8 mg buprenorphine a day, 1 500 mg dihydrocodeine a day, 400 mg heroin a day, 350 mg LAAM a week, 10 Mephenon[R] p. s a day, 50 mg methadone a day or 400 mg slow-release morphine a day.



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(methadone in pill form) must be taken daily. Heroin and dihydrocodeine must be taken at least twice daily.

Table 1 demonstrates that methadone is still the most commonly used substitution substance in the EU, although it no longer has the exclusive status it once did. Other substances have since appeared which, despite their diverse characteristics, are used for both detoxification and maintenance.

## Introduction of substitution treatments in the EU

Following an experiment in 1994–97 to prescribe heroin to chronic drug abusers mainly for maintenance purposes, Switzerland continues to use heroin as an alternative to methadone. The Swiss trial led to debates about heroin prescription in all EU Member States, and although similar trials were proposed in many, only the Netherlands actually launched them in 1997 while in Germany the legal framework for such trials was approved in 1999. French experiences with buprenorphine in 1996 led to similar small-scale experiments in Denmark (1998), Germany (1999) and Austria (1997) and to the licensing of the substance in the UK in 1999 and in Germany in 2000. LAAM trials spread from Portugal in 1994 to Spain in 1997 and Denmark in 1998.

While Table 2 again illustrates the predominance of methadone, it also demonstrates how long it took before methadone was introduced in all EU countries. Although in many countries newer substitution substances are still only on trial, they are increasing in importance.

**Table 2** Introduction of substitution treatments in the EU

| Country | Methadone treatment introduced | Introduction of other substitution substances (*) |
|---|---|---|
| Belgium | 1984 | Occasional use of buprenorphine (*), dihydrocodeine |
| Denmark | 1970 | Buprenorphine (*, [illegible]) and LAAM (both 1998) (*) |
| Germany | 1982 | Dihydrocodeine (1985), heroin (1999) (*), LAAM (1999), buprenorphine (2000) (*) |
| Greece | 1983 | No other substance prescribed |
| Spain | 1983 | LAAM (1997) |
| France | 1995 | Buprenorphine (1996) (*) |
| Ireland | 1970 | No other substance prescribed |
| Italy | 1975 | Buprenorphine (1999) (*, [illegible]) |
| Luxembourg | 1989 | Dihydrocodeine (1994) ([illegible]), Meptenon® ([illegible]) |
| Netherlands | 1968 | Heroin (1997) ([illegible]) |
| Austria | 1987 | Slow-release morphine (1997), buprenorphine (1997) (*, [illegible]) |
| Portugal | 1977 | LAAM (1994) ([illegible]) |
| Finland | 1974 | Buprenorphine (1997) (*) |
| Sweden | 1967 | No other substance prescribed |
| UK | 1968 | Buprenorphine (1999) (*) |

Notes: (*) Dates relate to the year the political decision was taken to prescribe the substance
(*) Buprenorphine is in the form of Subutex® and not Temgesic® as this only contains small amounts of the substance
(*) Trial only
(*) Data not known

An evaluation of outpatient methadone treatment in Germany from 1995 to 1999 carried out by the Institute for Therapy Research (IFT), Munich, revealed that drug consumption declined while social skills and relationships improved over the period.

A 1997 Dutch study showed that up to 90 % of clients on an average daily dose of 50 mg methadone also used cocaine and heroin, and 70 % used alcohol. First results of a study, initiated by the minister for health, into the effect of different methadone dosages on experimental groups show that the group receiving a higher dose became more stable, their health and social skills deteriorated less frequently and even improved somewhat more often.

In Austria, a 1997 evaluation reported that buprenorphine can be prescribed for pregnant women since babies born to mothers taking the substance do not demonstrate opiate-related abstinence syndromes as do babies of mothers taking methadone.

Whereas substitution trials with LAAM in the Netherlands failed in the early 1990s because addicts refused to participate, Portugal reported overall positive results, with 64 % of the 99 participants remaining in the programme. In a follow-up of 38 patients, 61 % did not relapse.

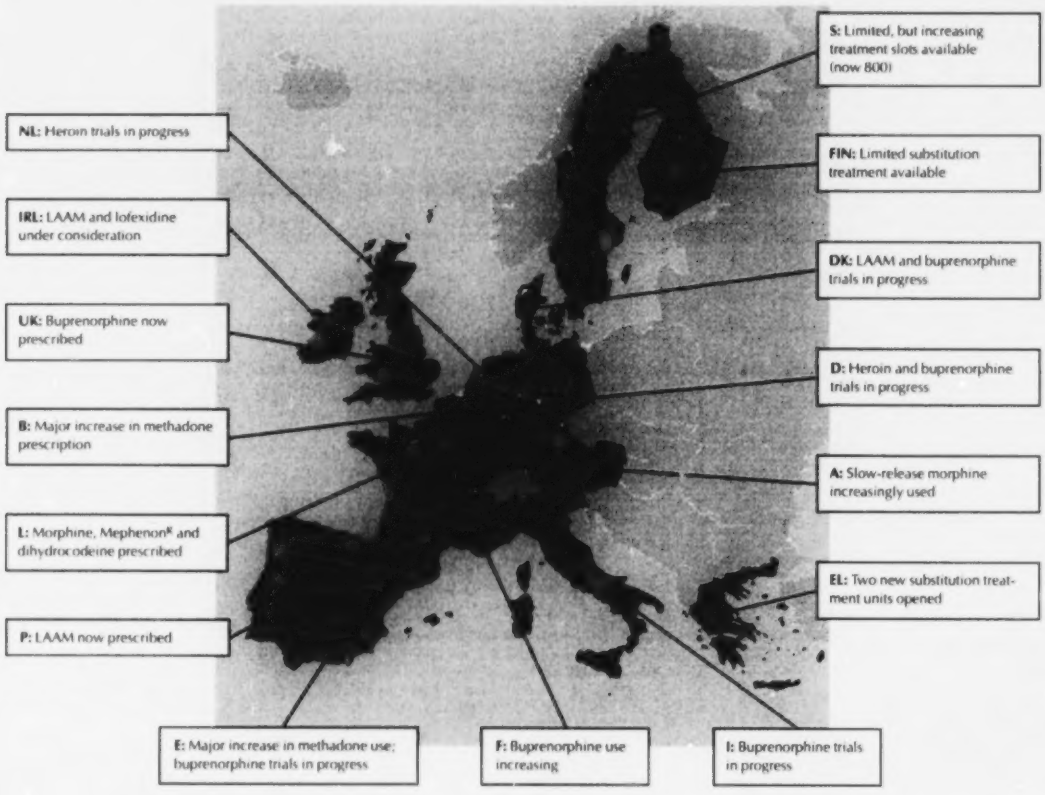
## Extent and settings of substitution services

Despite overall expansion in the EU in the last 30 years, substitution treatment is still scarce in some regions and settings. Services in Greece, Finland and Sweden, for example, have limited geographical coverage and may not reach potential clients in other districts. Availability of substitution treatment in prisons also varies, both between and within Member States.

Few Member States report limited in-patient substitution treatment, although the provision does, in theory, exist within the EU. Instead, substitution care is almost exclusively an outpatient service, possibly because outpatient treatment is cheaper than in-patient treatment but also because the effect on the clients' daily life is minimal. The outpatient setting does not, however, address the fact that those in substitution treatment range from relatively well-functioning often employed individuals to marginalised and extremely disadvantaged street addicts who may require more care than an outpatient facility can provide.

Despite substantial increases in the evaluation of substitu-

## An overview of substitution treatment in the European Union


S: Limited, but increasing treatment slots available (now 800)
NL: Heroin trials in progress
FIN: Limited substitution treatment available
IRL: LAAM and lofexidine under consideration
DK: LAAM and buprenorphine trials in progress
UK: Buprenorphine now prescribed
D: Heroin and buprenorphine trials in progress
B: Major increase in methadone prescription
A: Slow-release morphine increasingly used
L: Morphine, Mephenon® and dihydrocodeine prescribed
EL: Two new substitution treatment units opened
P: LAAM now prescribed
E: Major increase in methadone use; buprenorphine trials in progress
F: Buprenorphine use increasing
I: Buprenorphine trials in progress

tion treatment in the past five years, most Member States still report a lack of quality control, monitoring and assessment of individual programmes.

## Prosecution of drug-related offences

### Possession of heroin

In 11 EU Member States, the judicial authorities prosecuting the possession of small quantities of heroin or similar drugs must assess whether the substance is for personal use or not. Possession solely for personal use is considered less serious than possession for other purposes and the average sentence varies from administrative sanctions — such as confiscation of a driving licence or passport — to a fine or a custodial sentence for up to 12 months.

In practice, however, it may be impossible to define common criteria for prosecution — even within the same country — since the authorities must take into account such a broad range of factors, including the specific national drug laws, the status of the individual offender and where and when the offence occurred.

Some common elements can, however, be identified. In general, petty first-time offences — such as possession of very small quantities for personal use — lead to warnings, cautions and confiscation of the substance rather than more severe penalties. In Denmark, however, users possessing a single dose for their personal use may be allowed to keep it. In these cases confiscation is seen as counter-productive since a crime would probably have to be committed to pay for another dose.

Given its highly addictive nature, possession of heroin is likely to be a repeated offence, and recidivism is a major problem. In most Member States, recidivists face harsher prosecution measures, such as probation or custodial sentences, when the repeat offence involves 'considerable' quantities.

Possession of drugs such as heroin is still sentenced in markedly different ways in the EU. In Denmark, for example, a warning or fine may be imposed. In Greece,

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possession of small amounts of cannabis may in some cases be more strictly punished than possession of small amounts of heroin on the grounds that as heroin is addictive, the user is in greater physical need than the cannabis user. In the Netherlands, possession of small amounts of 'hard' drugs for personal use is not normally prosecuted, while in Finland those using 'hard' drugs will be more often prosecuted than those using 'soft' drugs, but the legal practice varies among individual courts.

## Property offences

In all Member States, offences committed against property to finance drug habits are serious crimes, and the fact that the offender is an addict has no independent influence. The sentence will, however, vary according to the circumstances of both the crime and the defendant.

Addicts who steal drugs from pharmacies or property from private homes to finance their drug use are most likely to be prosecuted. On conviction, they might receive a custodial sentence determined by the quantity of the property stolen and whether any violence — a major aggravating factor — was used. In Ireland, for example, possession of a syringe with intention to cause or threaten to cause injury or intimidation can lead to between 12 months and life imprisonment. Minor theft — such as shoplifting — or 'petty' theft — as defined by national law — incur milder sentences on condition that the defendant undergoes treatment for the addiction.

If a minor theft is committed by someone with no previous history of property crime and no severe addiction problems, the most likely response is a conditional sentence plus a fine, although prison is always an option. If, however, the offender has severe addiction problems and agrees to undergo treatment, the most likely response is probation, a suspended sentence and treatment.

Treatment as an alternative to punishment is a core principle in most Member States and forms the basis of Austria's national drug policy. Probation or suspended sentences are commonly applied and successful treatment closes the case. In Denmark, the results of an experiment conducted between 1995 and 1998 to treat instead of punishing addicted offenders are cautiously positive. Although many of the participants relapsed into drug use at least once, none reverted to crime during the experimental period. In Ireland, a pilot drug court programme will give courts the power to impose treatment on addicts and full responsibility for assessing their progress. Similarly, the 1998 UK Drug Treatment and Testing Order (DTTO) aims to reduce crime through court-oriented treatment and rehabilitation, which is mandated and monitored by the courts and supervised by the probation service. Even when a custodial sentence is imposed, a growing number of countries have increased treatment facilities in prisons.

## Selling drugs

Selling drugs to acquire money to finance a drug habit is a common behaviour among users throughout Europe and is considered a serious offence in all countries, whatever the circumstances. However, the extent of the crime is taken into account when imposing penalties which vary among countries and range from fines to a limited period in custody to life imprisonment in the UK.

Despite the very diverse data available across Europe, several common factors can be identified that influence the penalty for selling drugs.

### Quantity and customer

In most Member States, selling only small quantities of a drug is regarded as a mitigating circumstance compared to large-scale trafficking. In Greece, users who exchange small amounts of drugs amongst themselves proven to be exclusively for their personal use may receive a six-month prison sentence which can either be exchanged for a fine or suspended. Drug addicts involved in trafficking considerable quantities face up to eight years' imprisonment, whereas non-addicted offenders face life imprisonment. In Sweden, sentences vary from between two months and two years to up to three years depending on the quantity of the drug sold. Non-commercial supply is a mitigating factor in, for example, the UK.

### Degree of addiction

In all Member States, the degree of the offender's addiction may influence whether or not treatment-related measures rather than punishment are imposed.

### Nature of the substance

At judicial level, a distinction is made between the more dangerous and addictive drugs, such as heroin, and the less harmful and less addictive drugs, such as cannabis. In Greece, the police, in practice, have established priorities targeting drug trafficking according to the dangers associated with specific substances. Heroin is considered the most dangerous and is prosecuted the most severely followed by cocaine, synthetic drugs and cannabis. In Luxembourg, the current modification of the drug law involves re-scaling sentencing to reflect the dangers posed by different substances.

### Recidivism

Repeat offences can incur progressively heavier sentences in almost all Member States. In Denmark, repeated selling of very dangerous drugs can lead to up to six years' imprisonment. If 'considerable' quantities are



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involved, the sentence can be increased to a maximum of 10 years. In Luxembourg, sentences for selling any type of drug range from one to five years' imprisonment and/or a fine. For recidivists, these sentences can be doubled within the five years following the first offence. Since selling drugs is the most common way addicts finance their addiction, followed by minor thefts or burglaries, addicts are most likely to be recidivists. Yet even though such repeat offences are motivated by physical dependence, the response is more likely to be a heavy custodial sentence than treatment.

In the EU in general, although judicial authorities may see possession of small quantities of a drug for personal consumption as a mitigating circumstance, the line between possession and trafficking appears to be blurred. While distinct sentences for the two offences are applicable, no adequate parameters have yet been established to distinguish clearly between them and the same offence could result in different outcomes. While measures such as treatment as an alternative to prison are available in all Member States, the efficacy of their application has not yet been assessed at EU level.

## Problems facing women drug users and their children

Women-specific drug issues have not, to date, been systematically examined by EU drug-information systems. However, most Member States do address the needs of drug-dependent women through specialised programmes, although their extent and focus vary.

### Drug use among women

Overall, men use illicit drugs more than women. However, differences in drug use between men and women are complex and depend upon the specific substance used and the user's age, social group, educational level and geographical location. While boys tend to use cannabis more than girls, the difference is small or non-existent between the ages of 15 and 16. By 20 to 24, however, there is more male than female use. Gender differences in last-12-months prevalence and use of specific drugs are even more marked.

Earlier experimental drug use by girls than boys is generally the result of girls having older boyfriends who may encourage them to try drugs. As girls grow older, further gender-related differences in drug-use patterns appear and strengthen.

Although overall, drug use is more common among men than women, legal, cultural, educational and geographical factors account for increased prevalence among women. Gender variations in use are more marked where strong legal sanctions exist, as well as among early school leavers and rural populations. Differences are less evident where there is widespread acceptance, and use, of drugs such as cannabis. In Greece in 1998, drug (primarily cannabis) use was higher among men than women. Use by women, however, was six times higher than in 1984, whereas use by men increased less than threefold.

In direct contrast to illegal drugs, use of medicines such as benzodiazepines is more common among women than men and the difference increases with age. Compared with illegal drugs, the relatively low social stigma associated with licit and illicit use of medicines is notable, although the health consequences of regular use are considerable.

The number of women prisoners in Europe is steadily rising. In Spain, female prisoners have almost tripled during the past 10 years. Although a smaller proportion of convicted drug offenders are female, data from Ireland and the UK reveal significant levels of problem drug use among women on entry to prison, mainly involving heroin, methadone and benzodiazepines. Treatment facilities in women's prisons vary and guidelines for treating benzodiazepine dependence to prevent the dangers of sudden withdrawal do not appear to be as well developed as guidelines for treating opiate dependence.

Mortality directly related to illicit drug use appears to be lower among women than men, even allowing for gender differences in prevalence (on average, women account for only 20 % of drug-related deaths). Higher mortality in males can only be satisfactorily explained by studying the contextual and qualitative factors surrounding drug-related deaths.

### Infectious diseases

Anecdotal reports from Germany, France, Ireland and the UK suggest that there is some concern that HIV and hepatitis B infection are increasing among some female drug users. Although no hard data exist to support this concern, it has been suggested that it is the result of riskier injecting behaviour by women, or of unprotected sex.

Female drug users commit less property crimes than men and more often support their drug habits through the sex industry — sex work is an established source of income for up to 60 % of drug-using women. Rising HIV infection among European women and their new-born babies led to routine screening programmes for HIV and, in some cases, hepatitis B and C, in antenatal services in Germany, France, Ireland and the UK in the 1980s and 1990s. The potential of women to spread infectious

diseases to their clients has always caused concern and the connection between female drug use and sex work has almost certainly contributed to the growth in harm-reduction services for female sex workers and treatment services for female drug users. A number of outreach-work and low-threshold facilities for women have been established providing shelter, information and practical advice on safer sex and safer drug use. Self-help groups, such as Mainline in Amsterdam, offer services for women including hair-dressing, self-defence and drama.

## Pregnancy and women with children

Pregnant opiate users are increasingly seen as requiring a particularly high level of intervention and support. Most EU countries recognise that children born to these women may also need specific medical care. In all States, pregnant women are offered a 'fast track' into drug-treatment services, and in Belgium, Denmark, France, Ireland, Austria, Portugal and Sweden specialist services have been developed specifically for them. Detoxification is not generally recommended for pregnant women and substitution treatment options are under scientific review. For many of these women, however, regular maternity care is incompatible with their lifestyle or they fear stigmatisation if they attend.

The growing number of children born to drug users run a high risk of developing drug problems themselves and how children are affected by parental drug use and dependence is an emerging concern. Studies vary in both their methods and results. Some imply that the problems facing children of drug-using mothers are both inevitable and multiple, while others reveal no differences in the emotional, behavioural and learning problems of children of drug-using mothers and children of non-drug users in similar social settings. Other research points to similarities between children of drug-using and alcohol-dependent women. Mediating effects have been identified, such as modifying living arrangements, increasing social support and providing treatment facilities.

The extent to which children remain living with drug-using mothers varies widely in the EU and clear policies on removing children from drug-dependent mothers are either not yet developed or not standardised in practice. In Denmark and Sweden, which operate foster schemes, there appears to be a shift towards providing support to enable drug-dependent mothers to remain with their children, or at least to stabilise the relationship between children and parents. The more southern European countries — such as Greece, Spain, Italy and Portugal — tend to rely instead on traditional extended family structures to arrange appropriate childcare.

## Drug treatment

The ratio of female to male drug users in treatment tends to be less than 1:3. Women entering treatment tend to be younger than men and the proportion of women to men in treatment decreases with age. This may reflect age-related differences between men and women seeking

**Table 3**

| | Programmes addressing the needs of female drug users | | | | |
|---|---|---|---|---|---|
| | Pregnant women | Sex workers | Drug-using mothers and their children | Female prisoners | Schoolgirls and adolescents |
| Belgium | ++ | - | ++ | - | - |
| Denmark | ++ | + | + | - | - |
| Germany | - | + | ++ | + | + |
| Greece | + | + | + | - | - |
| Spain | - | ++ | + | + | - |
| France | + | + | - | - | - |
| Ireland | + | ++ | + | + | - |
| Italy | - | + | ++ | - | + |
| Luxembourg | - | + | - | - | - |
| Netherlands | - | + | + | - | - |
| Austria | ++ | + | ++ | - | + |
| Portugal | ++ | + | + | + | - |
| Finland | - | - | + | - | - |
| Sweden | ++ | - | + | - | ++ |
| UK | ++ | ++ | ++ | ++ | ++ |

Notes: - No information available or no programme reported
+ At least one programme reported
++ More than one programme reported

Sources: Revised national reports 1999. Dagmar Hedrich. Community-based services for female drug users in Europe. Pompidou Group of the Council of Europe, unpublished report, December 1999.



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treatment, or it may reflect changing patterns of drug use among women or both. Figures are generally thought to under-represent women with drug problems. In Belgium, a snowball survey revealed a higher ratio of female to male problem drug users than official treatment figures. A major reason for the low representation of women in drug treatment relates to motherhood: between 18 and 75 % of female clients have at least one child and are often too occupied with childcare to follow a treatment programme, or fear being labelled 'unfit' as a mother and having their children removed if they do enrol.

Only a few countries, such as Germany and Portugal, provide specific services in women's prisons, even though a high percentage of female prisoners use drugs. In Portugal, two prisons provide kindergarten services enabling children to remain with their mothers.

## Women-specific drug prevention

In Germany, Austria and Sweden, drug-prevention activities are oriented specifically towards very young women and schoolgirls. These initiatives often focus on female identity and how to refuse offers of drugs from boyfriends or other male peers.

The limited information presented here demonstrates how, in contrast to responses to male drug use which tend to focus on the crime-related impact of such use, responses to female drug use appear to be motivated more by concerns about the impact of the drug use on others: on children where the users are mothers; and on men where the users are sex workers.

Chapter 5

# The drugs problem in central and eastern Europe

The inclusion in this year's report of data on the drugs problem in the central and eastern European countries (CEECs) [6] reflects the growing cooperation between the EMCDDA and the candidate countries for accession to the EU [7]. As cooperation with Cyprus, Malta and Turkey is still in a preliminary stage, this chapter focuses on the CEECs involved in the EU Phare project on drug information systems [8].

Drug-related problems in the CEECs were generally limited until the geopolitical changes of 1989. Increased permeability of borders, greater movement of people and goods and a decline in traditional social values led both to new problems and exacerbated existing ones. Although drug trafficking through the region increased in the early 1990s, it had relatively little immediate effect on national drug consumption. Since then, however, the drug phenomenon has spread through all sectors of society.

## Overall trends

- The percentage of the general population, especially schoolchildren, who have tried illicit drugs at least once is increasing.
- The age of first use or first contact with both licit and illicit substances is decreasing.
- Demand for treatment for opiate dependency is increasing.
- Patterns of use are changing, with increased injecting and imported heroin taking the place of locally produced opiates.
- Drug use is spreading from major urban centres to all regions.
- Both drug-related arrests and seizures are increasing.

## Prevalence and patterns of drug use

### Cannabis

**School surveys**

Surveys of schoolchildren show that lifetime prevalence of drug use among 15 to 16-year-olds increased significantly between 1994 and 1999. Data on lifetime prevalence of cannabis use collected over several years by the European school survey project on alcohol and other drugs (ESPAD) reveal cannabis to be the most commonly-used drug, although there are some variations between countries.

**Treatment demand**

While most treatment initiatives in the CEECs focus on problem opiate users, Albania, Hungary and Slovakia report treatment demands for problem cannabis use. In the Czech Republic, the number of newly registered problem cannabis users in treatment has been rising over the past four years. Greater qualitative clinical and ethnographic research into this trend — which has also been observed in the EU — is now required if treatment programmes are to respond adequately.

[6] The CEECs are Albania, Bulgaria, Bosnia-Herzegovina, Czech Republic, Estonia, Former Yugoslav Republic of Macedonia (FYROM), Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.
[7] The candidate countries are Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia plus Cyprus, Malta and Turkey.
[8] Data are taken from the EU Phare national reports on drugs 1998 and 1999 and can only be considered a summary of general regional trends. No data are available for Bosnia and Herzegovina.

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**Table 4**

**Lifetime prevalence of drug use among 15 to 16-year-olds in four CEECs, 1994-99**

| Substance | | Lifetime prevalence | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
| Czech Republic | all illicit drugs | 26.4 | n.a. | n.a. | 43.8 | n.a. | n.a. |
| | cannabis | 21.5 | n.a. | n.a. | 35.4 | n.a. | n.a. |
| Hungary | all illicit drugs | n.a. | 4.8 | n.a. | n.a. | 12.5 | n.a. |
| | cannabis | n.a. | 4.5 | n.a. | n.a. | 11.5 | n.a. |
| Lithuania | all illicit drugs | n.a. | 3.2 | n.a. | 26.8 (*) | 13.3 (*) | n.a. |
| | cannabis | n.a. | 1.0 | n.a. | n.a. | 27.1 (*) | n.a. |
| Slovakia | cannabis | 8.1 | 12.4 | n.a. | n.a. | 19.7 | 23.0 |

Notes: (*) Vilnius only
(*) Ninth to eleventh grade pupils, Klaipeda only
n.a. = data not available

### Availability

Increasing numbers of seizures of marijuana and cannabis plants suggest that trafficking and local production are escalating in most countries, although this trend could also reflect improved law enforcement.

## Opiates

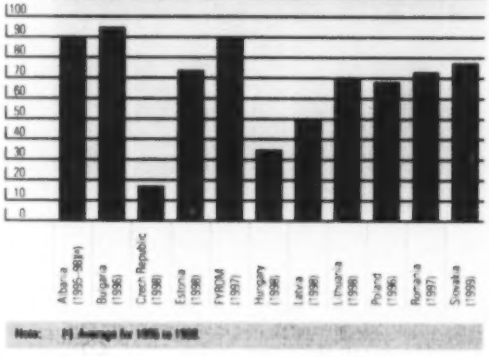
### Treatment demand

Opiates used in the CEECs include heroin — whose use in the region was negligible until the early 1990s — and substances derived from domestic production, such as 'Kompot' or poppy straw. Morphine and other opiates, including hydrocodeine, may be included in the second group, but are only found in a limited number of CEECs (hydrocodeine is only reported in Hungary).

Although data are not recorded in a systematic or harmonised way, demand for treatment for opiate use has clearly increased since 1993 in all CEECs.

In 8 of the 12 countries for which data are available, 70 to 90 % of registered treatment clients were opiate users in 1995 to 1998. Lower figures are reported in the Czech Republic (17 %), Hungary (34.7 %) and Latvia (49.4 %).

Fig. 22 Percentage opiate use among clients in treatment in some CEECs




Note: (*) Average for 1995 to 1998

Almost all countries report a decrease in the average age of opiate users in treatment. The most at-risk age groups are 15 to 19-year-olds and 20 to 24-year-olds, significantly younger than in the EU.

**Table 5**

**Number of treatment demands in the CEECs since 1993 (all substances)**

| | Year | | | | | |
|---|---|---|---|---|---|---|
| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
| Albania (*) | n.a. | n.a. | 27 | 62 | 334 | 523 |
| Bulgaria | n.a. | n.a. | 254 | 449 | n.a. | n.a. |
| Czech Republic (*) | n.a. | n.a. | 2 470 | 3 252 | 3 132 | 3 858 |
| Estonia | n.a. | 246 | 386 | 755 | n.a. | n.a. |
| Former Yugoslav Republic of Macedonia | 82 | 116 | 242 | 301 | 431 | n.a. |
| Hungary | n.a. | 2 808 | 3 263 | 4 233 | 7 945 | 8 957 |
| Latvia | n.a. | 784 | 1 289 | 1 517 | 1 738 | 1 970 |
| Lithuania | n.a. | n.a. | n.a. | 1 804 | 2 871 | 2 882 |
| Poland | 3 783 | 4 107 | 4 223 | 4 772 | n.a. | n.a. |
| Romania | n.a. | n.a. | n.a. | n.a. | 546 | n.a. |
| Slovakia | n.a. | 1 189 | 1 239 | 1 594 | 2 074 | 2 199 |
| Slovenia (*) | 141 | 187 | 125 | 309 | n.a. | n.a. |

Notes: (*) Data for Albania are from one single hospital
(*) First demand for treatment
n.a. = data not available



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In the Czech Republic, the average age of newly registered problem drug users in treatment fell from 22.8 in 1995 to 20.6 in 1998. Over 75 % of new clients began using drugs before they were 19, and more than 12 % before they were 15. The same trend is evident in the Baltic States. In Latvia, 41 % of all registered clients in treatment are under 19, and 22 % are under 15. Albania and Hungary also report a high percentage of clients aged 15 to 19, as well as increases in those aged 20 to 24.

**Intravenous drug use**

Intravenous drug use is a serious problem in the region, and is generally, but not exclusively, associated with heroin use. Variations, however, do exist between countries.

In Albania, 87.2 % of all clients in treatment use heroin, either alone or with other substances, yet intravenous drug use decreased from 29 % in 1995 to 19.3 % in 1998. In the Czech Republic, by contrast, the proportion of IDUs rose from 55 % in 1997 to 62 % in 1998. However, despite this increase, heroin accounts for only 17 % of the total problem drug use in the country. In 1998, 26.3 % of all registered treatment clients in Hungary were IDUs and 86 % of all heroin users injected. In Poland, only 50 % of clients in treatment in 1997 were injectors, and this figure is reported to have decreased significantly since then.

**Heroin versus domestic substance use**

Heroin consumption peaked in most CEECs between 1994 and 1995 and again from 1997 to 1998. This rise reflects an increase in availability which in turn has led to a drop in the use of more 'traditional', domestically produced opiates.

Albania and Latvia reported a rapid rise in heroin use in 1998, while in Estonia a move away from poppy straw to heroin was observed from 1997 to 1998. In Hungary, the proportion of addicts treated primarily for opiate use rose from 21.5 % in 1994 to 34.7 % in 1998. In parallel, sedative use declined from 27.8 to 12.2 %, and volatile substance use fell from 15.7 to 3.4 %. In Poland, the proportion of users of home-made opiates (so-called 'Polish' heroin) has been decreasing markedly, while the percentage of heroin users is increasing. Slovakia reported an increase in heroin use among treatment clients from 37 % in 1993 to 86 % in 1994.

**Geographic and social influences**

Since 1996, opiate use in the CEECs has been spreading from predominately major urban areas to most regions. In Slovakia, while only 35 % of heroin-dependent clients were treated outside Bratislava in 1994, this figure rose to 47 and 60 % in 1995 and 1996 respectively.

In Poland, disparities in opiate use have been recorded between major cities. For example, 70 % of all treatment clients in Warsaw and Krakow are primary opiate users. However, in Krakow the majority use home-made opiates while in Warsaw heroin is the primary drug consumed.

Variations in use between ethnic groups have also been reported within CEECs. In the Former Yugoslav Republic of Macedonia, for example, 1998 data show that young Macedonians tend to inject heroin whereas ethnic Albanians are more likely to smoke it. Similar differences have been reported with the Russian ethnic minority in the Baltic States and with the Roma community in Bulgaria.

**Drug-related diseases**

Although few reliable data concerning HIV, AIDS and hepatitis B and C are available in the CEECs, the prevalence of risk behaviours associated with intravenous drug use suggests that the danger of epidemics spreading remains high.

## Cocaine

Cocaine use is relatively rare in the CEECs, but as availability has increased so too have prevalence, trafficking and seizures. Compared with other drugs, cocaine is quite expensive and its use tends to be limited to higher-income brackets.

## Synthetic drugs

In the last four years, all synthetic drugs have grown in popularity — particularly in the three Baltic States, the Czech Republic, Hungary, Poland, Slovakia and Slovenia — and have become an integral part of youth dance culture.

As users of synthetic substances tend not to see themselves as 'drug users' or 'drug addicts', and thus rarely seek treatment, an accurate picture of the extent of synthetic drug use in the CEECs is hard to draw. Available data on both the number and quantities of drug seizures, however, seem to indicate that the spread of these substances is largely underestimated.

Use of amphetamines and amphetamine-type stimulants is increasing in the CEECs, although patterns of use vary. In the Czech Republic, use of pervitin, a methamphetamine, represents the most serious drug problem in the country (68 % of all problem drug users). Its use almost tripled among schoolchildren between 1994 and 1997. In Hungary, problem amphetamine use (mostly injected) accounts for 15.2 % of all treatment demands. In Lithuania, amphetamines appeared on the black market in 1996, and are consumed in tablets or intravenously. In Poland, amphetamines are increasingly offered to young

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people who have never previously used drugs. Romania reported significant seizures of amphetamines in 1997.

### Other substances

Other substances consumed in the CEECs — although not to the same extent in all — include sedatives and tranquillisers, inhalants and volatile substances.

In Hungary, sedative and benzodiazepine use accounted for 26 % of all treatment statistics in 1998, and for 17.9 % in Romania in 1997. In Latvia in 1998, 34.2 % of all psychotropic substance use involved volatile substances, while sedatives accounted for 10.1 %. In Slovakia, the proportion of volatile substance users among all treated clients was 10 to 11 % between 1994 and 1998, while sedative use accounted for 6 % of all demands for treatment in 1998. A national survey of 15-year-olds conducted in 1995 in Slovenia found a significant percentage of glue and other substance abuse, as well as of tranquillisers, particularly among girls.

Overall, drug consumption in the CEECs continues to rise.

## Responses

Over the last five years, most CEECs have attempted to counter the drug problem through institutional and legislative measures, demand-reduction activities (primarily prevention and treatment) and law enforcement.

### Institutional and legislative responses

Legislative responses continue with the integration of the *acquis communautaire* into the national laws of the 10 candidate countries. A wide range of new measures — covering money laundering, control of chemical precursors, alternatives to prison, and the consumption, production and trade in illegal drugs — as well as international conventions and reform of the penal code have been adopted by the CEECs since 1996.

But the formal creation of a new legislative framework is only a first step: defining how to apply new laws — as well as allocating the funds and human resources necessary to translate these principles into reality and to monitor their implementation — remain major challenges. In some cases, further analysis of legislative trends and increased cooperation will be necessary to avoid discrepancies in the policies of the EU Member States and the candidate countries.

While inter-ministerial structures have been established to coordinate drug-control efforts in all CEECs, frequent reorganisations of these structures, as well as a lack of funds, have led to the need for reinforced national coordination. Yet despite these frequent changes, sub-committees and working groups have contributed significantly to the preparation of draft legislative projects, as well as to draft national drug strategies.

Many CEECs are developing multi-disciplinary drug strategies but, because of the poor socioeconomic situation, as well as the many political and other challenges these countries face, they have not always been able to allocate the necessary budgetary resources for that purpose.

### Demand and supply reduction

The rise in cross-border drug trafficking, money laundering and diversion of precursors since the early 1990s has led to an increased emphasis on law enforcement in the CEECs. Controls over the supply of illicit drugs have been strengthened with the support of the EU's Phare programme.

Demand-reduction activities have been developed in all CEECs with the active support of international organisations and programmes including the EU Phare technical assistance to drug demand reduction project, the Pompidou Group of the Council of Europe, the World Health Organisation and ESPAD.

Many professionals working in the drugs field in the region have received training via these organisations, and new documents and methodological tools have been adapted and translated from material produced in the EU. Preventive and therapeutic programmes have also been created, building on the expertise available in the CEECs.

But despite these efforts, drug demand reduction remains a low priority in most CEECs, as reflected in the division of resources between the law-enforcement and demand-reduction sectors which favours law enforcement.

To some extent, the scarcity of resources and the difficult socioeconomic situation within individual countries have meant that funds provided through international support have influenced decisions regarding which actions should be developed. As a result, and despite the quality of those working in the field, many such activities have had a limited impact on the situation.

All forms of action need to be integrated into more coherent and effective national and regional strategies based on greater knowledge of the most problematic aspects of the drug phenomenon. As a result, strengthening the prototype national focal points in each CEEC, as well as the participation of the candidate countries in the EMCDDA's activities, could significantly benefit the decision-making process in these countries.

# EMCDDA publications 2000

## Online publications

### Annual publications

***Statistical bulletin***
online at www.emcdda.org
(available in English)

## Print publications

### Annual publications

***2000 Annual report on the state of the drugs problem in the European Union***
(available in all 11 official EU languages)

***1999 General report of activities***
(available in English, French and German)

### Newsletter

***DrugNet Europe***, Nos 21 to 26
(bimonthly newsletter, available in English, French, German, Portuguese)

### Scientific monograph series

***Methods to integrate epidemiological indicators to address policy-related questions on drug use***
Scientific monograph No 6
(available in English)

***Evaluation: A key tool for improving drug prevention***
Scientific monograph No 5
(available in English)

***Understanding and responding to drug use: The role of qualitative research***
Scientific monograph No 4
(available in English)

### Insights series

***Reviewing current practice in drug substitution treatment in Europe***
Insights No 3
(available in English)



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# Reitox focal points

**Belgique/België**
Institut Scientifique de la Santé Publique/ Wetenschappelijk Instituut Volksgezondheid
(Scientific Institute of Public Health)
Denise Walckiers
Rue Juliette Wytsman 14
B-1050 Bruxelles/Brussel
Tel. (32-02) 642 50 35
Fax (32-02) 642 54 10
e-mail: bim@iph.fgov.be
http://www.iph.fgov.be/reitox

**Danmark**
Sundhedsstyrelsen (National Board of Health)
Vibeke Graff
Amaliegade 13
PO Box 2020
DK-1012 København
Tlf. (45) 33 91 16 01
Fax (45) 33 33 00 18
e-mail: vig@sst.dk kag@sst.dk
http://www.sst.dk

**Deutschland**
Deutsche Referenzstelle der Europäischen Beobachtungsstelle für Drogen und Drogensucht
DBDD c/o IFT Institut für Therapieforschung (German Focal Point of the European Monitoring Centre for Drugs and Drug Addiction c/o Institute for Therapy Research)
Roland Simon
Parzivalstr. 25
D-80804 München
Tel. (49-89) 36 08 04 40
Fax (49-89) 36 08 04 49
e-mail: simon@dbdd.de
http://www.ift.de

**Greece**
University Mental Health Research Institute (UMHRI)
Greek Reitox Focal Point
PO Box 66517
GR-15601 Athens
Tel. (30-1) 653 69 02
Fax (30-1) 653 72 73
e-mail: akokke@mail.ariadne-t.gr
http://business.hol.gr/-umhri

ΕΛΛΑΔΑ
Ερευνητικό Πανεπιστημιακό Ινστιτούτο Ψυχικής Υγιεινής
(ΕΠΙΨΥ)
Τθ 66 517
15 601 Αθήνα
Τηλ. (30-1) 653 69 02
Φαξ (30-1) 653 72 73
e-mail: akokke@mail.ariadne-t.gr
http://business.hol.gr/-umhri

**España**
Delegación del Gobierno para el Plan Nacional sobre Drogas
Ministerio del Interior
(National Plan on Drugs DGPND)
Camilo Vázquez Bello
c/Recoletos, 22
E-28001 Madrid
Tel. (34) 91 537 27 25
Fax (34) 91 537 26 95
e-mail: cvazquez@pnd.mir.es
http://www.mir.es/pnd/index.htm

**France**
Observatoire Français des Drogues et des Toxicomanies
(French Observatory for Drugs and Drug Addiction OFDT)
Jean Michel Costes
105, rue Lafayette
F-75110 Paris
Tel. (33) 153 20 16 16
Fax (33) 153 20 16 00
e-mail: jecos@ofdt.fr
http://www.drogues.gouv.fr

**Ireland**
Health Research Board
Drug Misuse Research Division
Rosalyn Moran
73 Lower Baggot Street
Dublin 2
Ireland
Tel. (353-1) 676 11 76 extn 160
Fax (353-1) 661 18 56
e-mail: rmoran@hrb.ie
http://www.hrb.ie

**Italia**
Presidenza del Consiglio dei Ministri, Dipartimento per gli Affari Sociali, Ufficio per il coordinamento delle attività di prevenzione e recupero delle tossicodipendenze (Prevention and Rehabilitation Activities Coordination Unit, Department for Social Affairs of the Presidency of the Council of Ministers)
Franco Scarpino
Via Veneto, 56
I-00187 Roma
Tel. (39-06) 48 16 14 95
Fax (39-06) 48 24 934
e-mail:
puntofocale@affarisociali.it
http://www.affarisociali.it

**Luxembourg**
Direction de la Santé, Point Focal CEDT, Luxembourg (Health Directorate, EMCDDA Focal Point, Luxembourg)
Alain Origer
Allée Marconi
Villa Louvigny
L-2120 Luxembourg
Tel. (352) 47 85 625
Fax (352) 46 79 63
e-mail: alain.origer@ms.etat.lu
http://www.relis.lu

**Nederland**
Trimbos-instituut (Netherlands Institute of Public Health and Addiction)
Franz Trautmann
Da Costakade 45
PO Box 725
3500 AS Utrecht
Nederland
Tel. (31-30) 297 11 86
Fax (31-30) 297 11 87
e-mail: ftrautmann@trimbos.nl
http://www.trimbos.nl

**Österreich**
Österreichisches Bundesinstitut für Gesundheitswesen (Austrian Health Institute ÖBIG)
Sabine Haas
Stubenring 6
A-1010 Wien
Tlf. (43-1) 515 61 160
Fax (43-1) 513 84 72
e-mail: haas@oebig.at

**Portugal**
Instituto Português da Droga e da Toxicodependência (Portuguese Institute for Drug and Drug Addiction)
Elza Pais
Av. João Crisóstomo, 14
P-1000-179 Lisboa
Tel. (351-21) 310 41 00
Fax (351-21) 310 41 90
e-mail: mail:s@ipdt.pt
http://www.ipdt.pt

**Suomi/Finland**
Sosiaali ja terveysalan tutkimus ja kehittämiskeskus (National Research and Development Centre for Welfare and Health — STAKES)
Ari Virtanen
PO Box 220
FIN-00531 Helsinki
P./fin (358-9) 39 67 23 78
F./fax (358-9) 39 67 23 24
e-mail: ari.virtanen@stakes.fi
http://www.stakes.fi

**Sverige**
Folkhälsoinstitutet (National Institute of Public Health)
Bertil Pettersson
S-103 52 Stockholm
Tfn (46-8) 56 61 35 00
Fax (46-8) 56 61 35 05
e-mail: bertil.pettersson@fhi.se
http://www.fhi.se

**United Kingdom**
DrugScope
Nicholas Dorn
Waterbridge House
32/36 Loman Street
London SE1 0EE
United Kingdom
Tel. (44-20) 79 28 12 11
Fax (44-20) 79 28 17 71
e-mail: nicholas@drugscope.org.uk
http://www.drugscope.org.uk/index.html

**Norge (Observer)**
Norwegian Directorate for the Prevention of Alcohol and Drug Problems
Stein Berg
PO Box 8152 Dep.
NO-0033 Oslo
Tfn (47-22) 24 65 00
Fax (47-22) 24 65 25
e-mail:
Ingvild.Hoel@RusDir.dep.telemax.no

---

**European Commission**
Directorate General Justice and Home Affairs Drugs Unit
JAI/A/4
Timo Jetsu
Rue de la Loi 200 (Lx-46 5/93)
B-1049 Bruxelles
Tel. (32-0-2) 29-9 57 84
Fax (32-0-2) 29-5 32 05
e-mail: timo.jetsu@cec.eu.int
http://europa.eu.int/comm/justice_home/unit/unit4_en.htm



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# About the EMCDDA

The EMCDDA online

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